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**Family process at the point of alcohol rehabilitation  
Towards a systemic understanding of the transition to recovery**

Rosen, Andrea Nicole

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**Family process at the point of alcohol rehabilitation:**  
**Towards a systemic understanding of the transition to**  
**recovery**

Andrea Nicole Rosen

King's College London

PhD in Psychology

## Abstract

Theories of family functioning in the context of problem drinking suggest that the family system becomes organised to differing degrees to accommodate an alcohol dependent member, and this organisation influences the expression of addictive behaviour as well as family process. This interconnectivity means that changes in drinking behaviour have consequences that reverberate beyond the individual into the family space.

This project focuses on a very specific point in the life cycle of such families – when the alcohol dependent member enters residential treatment. It aims to understand (1) whether the state of family relationships at treatment entry is associated with patient outcome and (2) whether changes occur in family relationships across the rehabilitation process.

Two studies addressed these questions. First, a quantitative study of family process across the treatment and follow-up period was conducted. Alcohol inpatients were asked to complete measures of family and individual functioning before, during and after treatment to detect change in key variables and investigate baseline predictors of outcome. Second, a qualitative interview study explored families' own experiences of residential rehabilitation post-discharge. Grounded theory was used to identify common themes and processes.

Results from these studies suggest that the family context is indeed a relevant consideration during residential rehabilitation. Patients' satisfaction with their family relationships was predictive of treatment drop-out, and families themselves experienced considerable change during the transition to sobriety. In consequence, it is proposed that a more systemic view of alcohol dependence and recovery at point of treatment would benefit both patients and their family members.

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## Statement of contributions

The current programme of research is based on an original proposal developed by the author, which was funded by the Economic and Social Research Council as a PhD studentship. Professor Ivan Eisler supervised the writing of the proposal as well as the execution of the project, with Dr Jane Marshall and Professor Elizabeth Kuipers acting as co-supervisors in this latter task. Dr Marshall provided introductions to colleagues in the addictions field which facilitated the establishment of the study sites.

Lucy Carlisle and Sam Ollman-Hirt, both students from the MSc programme in family therapy at the Institute of Psychiatry, Psychology and Neuroscience, conducted family interviews 1-8 and patient interviews 1-7 respectively as part of Study 2, as well as transcribing and coding this data. Their work was supervised by the author, who checked the transcriptions and acted as a second coder. A detailed account of this process can be found in the procedure section of Chapter Four.

Mizan Khondoker, John Hodsoll and Victoria Harris from the Statistical Advisory Service at the Institute of Psychiatry, Psychology and Neuroscience were consulted in the development of the data analysis strategy for the project.

All other work is that of the author.

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## Chapter One: Introduction

*“Individuals do not take drugs in isolation from what is happening in the rest of their lives”* (HM Government, 2010, p. 2).

HM Government’s most recent drug strategy began with this statement by Home Secretary Theresa May, acknowledging the importance of contextualising drug and alcohol misuse as part of a new policy emphasising long-term recovery over harm reduction. The family environment is one such context in which problematic use occurs. Theorists and researchers have been analysing the relationship between the substance dependent person and his or her family, generally acknowledged to be a recursive one, since the 1950s, but policy makers and treatment providers have been slow to integrate the implications of this systemic thinking into practice. However, in the current treatment environment, where limited funding is allocated to providers who can prove positive patient outcomes, perhaps the time has come to pay more attention to the family and its impact – both positive and negative – on substance misuse behaviour.

Cloud and Granfield introduced the concept of recovery capital to the addictions field from sociology, defining it as “the sum total of one’s resources that can be brought to bear on the initiation and maintenance of substance misuse cessation” (Cloud & Granfield, 2008, p. 1983). The Joint Commissioning Panel for Mental Health has adopted the concept, making the enhancement of recovery potential part of their model of service delivery for substance dependence (Joint Commissioning Panel for Mental Health, 2013). The essential question at point of treatment then is – how do a patient’s family relationships contribute to his or her recovery capital? On the one hand, these relationships

are a potential resource for patients during the treatment process; on the other, those aspects of family life which do not promote recovery must be addressed through deliberate intervention. By extension, does the family respond to the rehabilitation process in its own right? Evidence of long-term stress and strain in these families means their needs must also be considered at this juncture (Orford, Copello, Velleman, & Templeton, 2010).

This thesis focuses on such alcohol dependent patients and their families, and aims to understand (1) whether the state of family relationships at treatment entry is associated with patient outcome and (2) whether changes occur in family relationships across the rehabilitation process. It takes as its population the most severely dependent alcohol patients, those who undertake an inpatient detoxification programme before going on to long-term residential rehabilitation. Drawing on a systemic understanding of alcohol misuse, which assumes that families become organised around addictive behaviour (Steinglass, Bennett, Wolin, & Reiss, 1987), it recognises both the impact of problem drinking on families and their potential to influence its expression.

This introductory chapter will provide an overview of alcohol dependence, its prevalence and costs, as well as a summary of patient care pathways and prognosis. It will address the number of family members affected, the costs incurred by them, and their relative neglect in the treatment setting. Finally, it will describe recent changes in alcohol service provision in the United Kingdom (UK) and how these changes make the current moment a particularly relevant one in which to consider family factors and their impact on alcohol treatment outcomes.

### Defining alcohol misuse and dependence

In 1785, the American doctor Benjamin Rush published a pamphlet entitled ‘An inquiry into the effects of ardent spirits on the human body and mind.’ Within, he

elaborated for the first time the concept of alcohol dependence, taking what was seen as a moral problem out of the hands of the church and making “this odious disease (for by that name it should be called)” a province of the medical establishment (Rush, 1785, p. 5).

British naval physician Thomas Trotter extended the disease model from medicine to psychology in 1804, stating that “it is to be remembered that a bodily infirmity is not the only thing to be corrected. The habit of drunkenness is a disease of the mind” (Trotter, 1804, p. 179). Since then, both medicine and psychology have attempted to describe and classify alcohol misuse disorders, as well as to differentiate problematic from non-problematic drinking behaviour.

Current clinical classifications owe much to Edwards and Gross’s description of what they called alcohol dependence syndrome in 1976. Cataloguing the key elements and patterns common to their alcohol patients, their list prefigured the diagnostic criteria developed later by the World Health Organization (WHO; ICD-10) and the American Psychiatric Association (APA; DSM-5). Edwards and Gross proposed 7 key components of dependence, not all of which needed to be present and which varied in their degree of intensity: a narrowing of drinking repertoire, prioritising alcohol intake, increased tolerance to alcohol, withdrawal symptoms, relief of withdrawal symptoms through increased consumption, a compulsion to drink, and the reinstatement of dependence after abstinence (Edwards & Gross, 1976).

Later diagnostic criteria have identified two categories of problematic alcohol use: abuse or harmful drinking, and dependence. Only recently, in the latest edition of the APA’s Diagnostic and Statistical Manual of Mental Disorders (DSM-5), have these traditional classifications been abandoned in favour of a continuum of misuse ranging from mild to severe (American Psychiatric Association, 2013). The previous version of the

DSM (DSM-IV-TR) focused on the social consequences of alcohol use when defining abuse (e.g. failure to fulfill personal and professional obligations, interpersonal and/or legal problems) and defined dependence by the further inclusion of physiological consequences (e.g. tolerance, withdrawal, progressively increasing consumption) (American Psychiatric Association, 2000). Now, the presence of any 2 of the 11 physical, psychological and social effects of alcohol use indicates a mild alcohol use disorder, 4-5 indicates a moderate disorder, and 6 or more indicates a severe disorder (see Box 1.1).

Box 1.1: DSM-5 diagnostic criteria for Alcohol Use Disorder

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving, or a strong desire or urge to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
8. Recurrent alcohol use in situations in which it is physically hazardous.
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
10. Tolerance, as defined by either of the following:
  - a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
  - b. A markedly diminished effect with continued use of the same amount of alcohol.
11. Withdrawal, as manifested by either of the following:
  - a. The characteristic withdrawal syndrome for alcohol.

b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms.

Source: American Psychiatric Association (2013)

The WHO's definition of abuse, which they term harmful drinking, is broader, consisting of any drinking behaviour causing physical or mental damage to health (World Health Organization, 1992). They define dependence in their most recent revision as "a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state" (World Health Organization, 1992). Both the ICD and DSM diagnostic criteria agree that the severity of an alcohol misuse disorder is determined by the presence of a variety of biopsychosocial symptoms, none of which are essential; this means that the character of the disorder, while containing familiar elements, will vary in its individual presentation.

In addition to the formal diagnostic criteria enumerated by international professional bodies like the APA and the WHO, the UK government offers its own, more practical criteria to help the public understand what constitutes a harmful level of consumption. In 2012, the House of Commons Science and Technology Committee reviewed the guidelines for sensible drinking laid out in 1995 by the Department of Health and confirmed their continuing validity. These guidelines establish upper daily limits for both men and women (3-4 units and 2-3 units respectively) and recommend a period of 48 hours' abstinence after heavy drinking (House of Commons Science and Technology Committee, 2012). Anything above this is seen to carry an increasing risk to health.

## Prevalence and costs of alcohol dependence

The Office for National Statistics reports a prevalence of alcohol dependence in England of 5.9%, comprising 8.7% of men and 3.3% of women (Health and Social Care Information Centre, 2015). Given an English population of 54.3 million (Office for National Statistics, 2015), this means approximately 3.2 million people will have some degree of dependence on alcohol. Mild dependence accounts for the majority of cases (5.4%), with moderate and severe dependence less frequently encountered (0.4% and 0.1% respectively) (Health and Social Care Information Centre, 2015). These figures, however, are based on a household survey of adult psychiatric morbidity whose authors warn that they are likely an underestimate; they do not include dependent drinkers among the homeless or the institutionalised.

The most recent national alcohol strategy (2012) looks at the prevalence of alcohol misuse more broadly. For a UK population of 64.6 million (Office for National Statistics, 2015), 13.9 million are estimated to be regularly drinking above the lower-risk levels (21.5%), more than 1.9 million show some signs of dependence (3%) and over 323,000 are moderately or severely dependent (0.5%) (HM Government, 2012). Based on these two reports then, a minimum of 2-3 million individuals across the UK can be said to have some level of dependency on alcohol, with more than 13 million drinking at levels which put them at risk of alcohol-related harm and increasing dependence.

All of this has consequences for society at large, and measuring the economic cost of alcohol misuse is one way to approximate its wider impact. According to the government's alcohol strategy, alcohol-related harm costs the UK £21 billion each year (HM Government, 2012). In England alone, the National Health Service expends £3.5 billion annually on alcohol misuse, and the resulting loss of individual productivity costs



the UK economy £7.3 billion per year. Alcohol-related crime is worth an estimated £11 billion per annum in England (Department of Health, 2012). As a specific population, dependent drinkers cost the NHS twice as much as other alcohol misusers (HM Government, 2010), and increasing effective specialist treatment for them offers the most immediate savings opportunity for the health service (HM Government, 2012). It has been estimated that every £1 spent on treatment for dependent drinkers would save the UK public £5 in health, social or criminal justice costs (UKATT Research Team, 2005a).

### [Alcohol care pathway and prognosis](#)

The National Institute for Health and Care Excellence (NICE), which develops treatment guidelines in the UK based on evidence from current research and best practice, recommends specific care pathways for alcohol dependence (NICE, 2011). Pathways begin with assessment to determine whether the patient will need detoxification as a first step – this is the criterion used by NICE to establish the presence and severity of alcohol dependence. Those who can overcome their physiological dependence without a structured withdrawal programme are considered to have mild dependence, while those who need assisted detoxification but can be managed in an outpatient, or community, setting are considered moderately dependent. The most severely physiologically dependent users require an intensive residential detoxification (NICE, 2011). The Severity of Alcohol Dependence Questionnaire (SADQ; Stockwell, Sitharthan, McGrath, & Lang, 1994), which measures the intensity of withdrawal symptoms and the patient's psychological experience, is used by NICE to make this assessment; clinicians will likely also consider other variables, such as the patient's history of withdrawal events and the ability of their home environment to support successful withdrawal (Marshall, Humphreys, & Ball, 2010).

Once a detoxification plan is in place, post-discharge interventions are recommended for patients at each level of dependence. For those patients whose drinking is harmful or mildly dependent – those that do not need a medically assisted detoxification – NICE recommends psychological therapies in an outpatient setting as well as adjunctive pharmacological treatment to reduce consumption. Individual cognitive behavioural, behavioural or social network therapies are suggested as first line treatment, as well as behavioural couples therapy for those with partners. Sessions should be focused on alcohol issues regardless of the modality (NICE, 2011).

For those patients who are moderately dependent, psychosocial support is suggested alongside an outpatient, medically assisted detoxification. This is described as 2-4 meetings per week with support staff for at least one week. Detoxification for severe dependence is managed by a similar combination of social and pharmacological support in a residential setting, but NICE recommends service users attend an intensive day programme in the community for 3 weeks after withdrawal from alcohol. Such a programme would include pharmacological maintenance treatment as well as the alcohol-focused individual or couple psychological interventions described above (NICE, 2011).

In the NICE guidelines, residential rehabilitation after detoxification is only recommended for alcohol dependent patients who are homeless; the authors question whether intensive community programmes may not be as effective as residential treatment, and call for further large-scale research on the topic (NICE, 2011). The National Treatment Agency (now part of Public Health England), however, asserts that residential rehabilitation centres are an integral part of the UK treatment landscape, and especially suited to the needs of complex users. Residential clients will typically have physical and psychological comorbidities, social and housing problems, polydrug use, long-term

dependency histories and/or previous failed treatment attempts, all of which indicate the need for intensive specialist treatment (National Treatment Agency for Substance Misuse, 2012b). Residential services vary in the content of their programming, but typically include some combination of individual and group therapy, social and vocational skills training and psychoeducation (National Treatment Agency for Substance Misuse, 2012b).

Data from the National Drug Treatment Monitoring System (NDTMS) give some indication of the relative use of each care pathway and the number of people accessing alcohol services. In the financial year ending March 2014, 114,920 alcohol dependent individuals were engaged in treatment in England (Public Health England, 2014a). This treatment overwhelmingly took place in community settings (~89%), including primary care, with the most severely afflicted patients split between inpatient units (7%) and residential rehabilitation programmes (3%) (Public Health England, 2014a). Of those clients exiting treatment during the same period (n=74,291), 59% were successful completions, defined by the NDTMS as planned discharge free from dependency, where the patient is either abstinent or drinking at a level that does not require further treatment (Public Health England, 2014a). An audit of residential rehabilitation clients from 2010-2012 found that these specific clients had a lower success rate overall – only 38% successfully completed rehabilitation free from dependency (National Treatment Agency for Substance Misuse, 2012b). This is consistent with the more complex user profile described above. Historical data show that provision of service along the care pathway relevant to this thesis has not changed much over time: since 2008, roughly 10% of service users annually have had an inpatient detoxification and 4% have gone on to residential rehabilitation afterward (Public Health England, 2014a).

## Impact on family members

As discussed above, upwards of 2-3 million individuals across the UK can be said to have some level of dependency on alcohol, with more than 13 million drinking at harmful levels. When we consider those in close proximity to alcohol misuse, the problem balloons. Described as a “neglected contributor to the global burden of adult ill health” (Orford, Velleman, Natera, Templeton, & Copello, 2013, p. 70), exposure to addictive behaviour can have a profound effect on the mental and physical health of close adult family members (Orford, Copello, et al., 2010). Unfortunately there is no requirement to routinely collect data on adult family member involvement as part of addiction services (Copello, Templeton, & Powell, 2010; Kydd & Roe, 2012), and so the true scale of the problem can only be approximated. Using Orford et al.’s conservative estimate of one adult affected per alcohol misuser, the number of adults adversely affected by proximity to alcohol dependence would be equal to the alcohol dependent population itself, or 2-3 million people (Orford et al., 2013).

When one considers the wider network of adult family members and close friends, these figures increase exponentially (Copello, Templeton, & Powell, 2010). According to data from the 2000 National Psychiatric Morbidity survey (Coulthard, Farrell, Singleton, & Meltzer, 2002), 7% of mildly alcohol dependent respondents had less than 4 people in their primary support group, 27% estimated their support network at 4–8 people and 67% thought their support group was larger than this. Among the moderately and severely alcohol dependent, the figures were 18%, 42% and 40% respectively. This gives an idea of the extent of the ripple effect that alcohol dependence may have among adult family and friends.

The children of alcohol misusers are a particularly vulnerable group. An extensive body of literature confirms the far-ranging consequences experienced by these children, from psychological, social and behavioural problems to the eventual intergenerational transmission of substance abuse (Arria, Mericle, Meyers, & Winters, 2012; Johnson & Leff, 1999; Sher, Grekin, & Williams, 2005). According to a recent report produced by Addaction, more than 3.3 million children in the UK live with either a hazardous or dependent drinker (2.6 million and 705,000 respectively) (Kydd & Roe, 2012). In the treatment seeking population, 33% have direct responsibility for a child, and a further 20% are parents whose child resides elsewhere (HM Government, 2012).

The Department of Health's alcohol-related harm estimate explicitly does not include the economic impact of alcohol misuse on families and social networks (Department of Health, 2012). Attempts to quantify these wider costs have been fraught due to the difficulty of determining the size of the population affected; the lack of routine data collection on family and wider support networks has contributed to the problem of estimation. No major calculation of the cost of alcohol dependence or misuse on the family has been undertaken. In a report to the UK Drugs Policy Commission, however, Copello and colleagues attempted to calculate the financial burden on the families of drug users. Taking into account day-to-day support costs, costs incidental to the drug use itself, the impact of crime and lost employment opportunities, as well as excess healthcare costs, the authors estimated £9497 is spent annually by each family member, contributing to a total cost of £1.8 billion to these families in the UK (Copello, Templeton, & Powell, 2009). While alcohol misuse is not directly comparable to drug use, it is reasonable to assume that the cost categories are similar, and that the population affected will be larger due to the

higher prevalence of alcohol as compared to drug use (Copello, Templeton, & Powell, 2010).

### Provision of services to family members

In a recent report, Addaction described the lack of a universal service provision for the families of alcohol misusers, stating that they are likely instead to receive patchy and ineffective support from a variety of agencies tangentially involved in their care, such as the police or social services (Kydd & Roe, 2012). A study by the UK Drug Policy Commission found that the majority of treatment organisations did not have a service specifically for family members – even as a component of their provision to patients, work with family members alone accounted for less than 10% of the workload in most organisations (Copello & Templeton, 2012). As 89% of the services surveyed in the study worked with both alcohol and drugs, this figure gives some indication of the offering in the alcohol treatment setting as well.

The continuing state of neglect that families receive from services is surprising given the increased attention paid to families in alcohol policy in recent years. Though historically both alcohol policy and alcohol services have been overwhelmingly focused on the dependent individual (Velleman, 2010), recent policy initiatives such as the *Think Family* campaign have encouraged the adoption of a systemic viewpoint in dealing with problems such as substance misuse (Social Exclusion Task Force, 2008). The most recent alcohol strategy acknowledges the role of the family context in influencing drinking patterns both positively and negatively (HM Government, 2012), and the current NICE guidelines on alcohol use disorders explicitly require intervention on behalf of supporting family members (NICE, 2011). They also recommend a range of systemic therapies, described above, as components of best practice for treating dependence. The

government's drug strategy has encouraged the promotion of family stability as a mechanism for sustaining longer-term recovery (HM Government, 2013), going so far as to suggest that improved relationships be a measured treatment outcome (HM Government, 2010). Both the National Treatment Agency and the Joint Commissioning Panel for Mental Health recommend integrating commissioning for families (National Treatment Agency for Substance Misuse, 2012a).

However, as Velleman notes, policy is often symbolic of a government's priorities and does not necessarily result in implementation (Velleman, 2010). While the family's role is acknowledged in the government's alcohol strategy, none of the action items the government is explicitly committing to relate to these families, save a broader initiative targeting the 120,000 most troubled families which may or may not include them (HM Government, 2012). The primary target of family-focused measures in national substance misuse policy generally are the children of substance dependent parents – and while this vulnerable population needs attention, such a narrow focus neglects the wider system of adult relatives impacted by alcohol misuse, a resource which could be used to help the patient as well as any affected children (Velleman, 2010). And despite the 2011 NICE guidelines, Copello and colleagues found that the NHS and social services overwhelmingly interacted with family members as part of their service to substance misusers, and not as a population in their own right (Copello & Templeton, 2012).

There are many barriers to extending service provision to family members. Individually oriented drug and alcohol services face a host of practical constraints, from record-keeping systems organised around individual clients to appointment procedures and therapeutic materials that assume no family involvement (Orford, Templeton, Copello, Velleman, & Ibanga, 2010; Orford et al., 2009). Attempts to integrate family work into

standard drug and alcohol treatment have found practitioners interested but hesitant, lacking the training or the confidence to work systemically, and concerned about the appropriateness of including family members at all (Orford, Templeton, et al., 2010; Orford et al., 2009). Capacity and funding for such work is extremely limited, especially in statutory services, and after a two year family integration project, Orford et al. (2009) concluded that changes were modest, achieved with difficulty, and not likely to be sustainable. The project's positive outcomes were still primarily focused on the user: of the 503 sessions conducted, up to 100 sessions included family involvement, but only 7 were attended by a family member alone (Orford et al., 2009).

#### Changes in alcohol service provision in the UK

The current moment provides an opportunity for rethinking the place of family services in the treatment setting. In 2010, the government published a new drug strategy which fundamentally changed the commissioning of drug and alcohol services in the UK, as well as the goals of these services. The strategy put responsibility for designing and contracting treatment into the hands of the local authorities instead of the National Health Service, asserting that the former were better placed to assess local needs (National Treatment Agency for Substance Misuse, 2012b). At the same time, the strategy outlined a shift in policy away from a harm reduction model for managing drug and alcohol misuse to a recovery-orientated model that identified abstinence as the overriding service goal (HM Government, 2010). Practically speaking, this meant that it was not treatment entries that would be the primary measure of the policy's success (as they were under the harm reduction model), but treatment outcomes instead (Monaghan, 2012).

The shift to local authority control was completed in April 2013. According to a survey conducted after the first year of the new system, all respondents (94% of local



authorities) stressed that the sector as a whole was under substantial financial pressure, with 36% reporting intent to reduce funding for drug and alcohol services over the next two financial years (Public Health England, 2014b). In this climate, local authorities are struggling to balance the demand for alcohol services in their communities with a decrease in available funds and competing public health needs (National Treatment Agency for Substance Misuse, 2012b). As a consequence, and consistent with the new recovery-oriented national policy, alcohol service providers have been under mounting pressure to show evidence of successful treatment outcomes to secure continued funding. This is especially true for residential rehabilitation services, which are up to five times more costly than treatment in the community (National Treatment Agency for Substance Misuse, 2012b).

In order to drive effective commissioning, local authorities surveyed in the above-referenced report called for the evidence base around drug and alcohol services to be strengthened (Public Health England, 2014b). They wanted proof not only of value for money in terms of patient treatment outcomes, but also confirmation that investing in drug and alcohol services would benefit the wider local population. If it could be shown that at point of treatment family relationships are predictive of patient outcome, it would provide some evidence for maintaining provision for families within drug and alcohol services. This would not only benefit patients and treatment providers – through improved outcomes and thus safer funding streams – but would address the wider public health problem of family and friends affected negatively by their proximity to alcohol misuse, who constitute a neglected and costly population in their own right.

## Chapter Two: Literature review

The following chapter will review the research literature which examines how the alcohol dependent individual and his or her family impact one another. It will be shown that while the negative effect of alcohol dependence on the family is well documented, little research has examined the reverse case: how the state of family relationships impacts the alcohol patient, and how this might influence treatment outcomes. In order to demonstrate how the family might contribute to a patient's recovery capital (as defined in the previous chapter), theoretical models which illustrate the mutuality of the family's relationship with an alcohol dependent member will be presented, as well as a growing body of evidence for systemic interventions which utilise family relationships to achieve change in a clinical setting. As no study to date has investigated changes in family factors prospectively during residential alcohol treatment, research on other wet-to-dry transitions will be used to show that the family context is responsive to changes in drinking behavior, suggesting that families are likely to react to the rehabilitation process in their own right.

In order to conduct an exhaustive review of each of these subtopics, three databases (PsycINFO, MEDLINE and Embase) covering the psychological and biomedical literature were first searched. Multiple search strings were utilised: keywords and their synonyms were entered in a variety of combinations to ensure relevant papers were captured (see examples in Table 2.1 below). Once these were identified, their reference lists were reviewed, as well as the papers citing them, in order to understand the evolution of the literature for each particular topic and ensure there were no gaps in the review.

Table 2.1: Example search strings used during literature review

| <b>Subtopic</b>                            | <b>Example search string used</b>   |
|--|---|
| Predictors of alcohol treatment outcome    | {“alcohol dependence” OR “alcohol*”} AND {“treatment dropout” OR “treatment adherence” OR “treatment outcome”}      |
| Impact of alcohol use on the family        | {“alcohol dependence” OR “alcohol*”} AND {“family functioning” OR “family relations”}                               |
| Family process during relapse and recovery | {“alcohol dependence” OR “alcohol*”} AND {“relapse” OR “recovery”} AND {“family functioning” OR “family relations”} |

### Outcomes of family members exposed to alcohol misuse

In a summary of over 800 interviews with adult relatives of drug and alcohol misusers, Orford and colleagues suggest that despite sociocultural, age and gender differences, the fundamental experience of family members affected by substance misuse is universal (Orford, Velleman, Copello, Templeton, & Ibanga, 2010). The authors identify the primary common factor of this experience as stress (Orford, Velleman, et al., 2010), and principal components analysis further distinguished two specific sources: (1) family members’ worry about the substance misuser and the consequences of his or her use for the family and (2) acute disturbance to the family environment (Orford, Templeton, Velleman, & Copello, 2005; Orford et al., 2013). Relatives have often been exposed to these stressors for long periods of time (Orford, Copello, et al., 2010); alcohol dependence, for example, with its progressive, relapsing-remitting natural history may be considered a chronic condition (McLellan, Lewis, O’Brien, & Kleber, 2000). As is the case for family members of those with other persistent mental and physical illnesses (Holmes & Deb, 2003; Lim & Zebrack, 2004; Magliano, Fiorillo, De Rosa, Malangone, & Maj, 2005; Sales, 2003), if coping mechanisms are insufficient to manage the stress, it becomes physical and

mental strain, and family members become symptomatic (Lazarus & Folkman, 1984; Orford, Copello, et al., 2010).

Using data from the 3.2 million members of the Kaiser Permanente healthcare company in northern California, Ray, Mertens and Weisner (2007) found that relatives of patients with an alcohol or drug diagnosis had approximately \$500 (£324) more in annual healthcare costs in the two years prior to their relative's diagnosis than a comparison sample. Relatives were also more likely to be diagnosed with 15 health conditions themselves, most notably depression and substance misuse (OR 1.9 and 2.2 respectively). Indeed, the health effects suffered by these family members surpassed those experienced by family members coping with other chronic conditions, such as asthma or diabetes (Ray, Mertens, & Weisner, 2009). Additional analyses of the Kaiser Permanente database in 2010 by Weisner et al. replicated this finding across a number of service settings (e.g. accident and emergency, primary and outpatient care), noting an even larger, fivefold difference in psychiatry and substance misuse costs. They also found that relatives of those who had made an unsuccessful treatment attempt had increasing medical expenses in the 4 years post-discharge compared to controls and the relatives of those maintaining abstinence (Weisner, Parthasarathy, Moore, & Mertens, 2010). Overall, those in close proximity to alcohol misuse report lower levels of health, wellbeing and quality of life (Casswell, You, & Huckle, 2011; Ferris, Laslett, Livingston, Room, & Wilkinson, 2011), and they are also at a heightened risk for interpersonal violence (Leonard & Eiden, 2007).

Children are similarly affected. In the Kaiser Permanente study described above, Ray et al. (2007) found that children who were listed as dependents of those with a drug or alcohol diagnosis had 28% higher healthcare costs than controls, and were more likely to be diagnosed with 10 different medical conditions themselves. Substance misuse and

depression were nearly 3 times as prevalent in these children as in their peers (OR 2.5 and 2.8 respectively). A considerable evidence base catalogues the behavioural and social problems experienced by children exposed to alcohol misuse, including conduct disorder, difficulties with self-regulation, social isolation and academic underachievement (Adkison et al., 2013; Hussong, Huang, Curran, Chassin, & Zucker, 2010; Leonard & Eiden, 2007; Molina, Donovan, & Belendiuk, 2010; Velleman & Templeton, 2007). The prevalence and early onset of internalizing (e.g. negative emotionality, depression, anxiety) and externalising behaviour (e.g. undercontrol, impulsivity) in this group strongly predicts later substance misuse diagnoses (Zucker, 2006), for which these children are already significantly at risk (Chassin, Forth, & King, 2004; Johnson & Leff, 1999; Sher et al., 2005).

At the same time, however, a number of studies have shown that exposure to alcohol in the home is not the sole determinant of outcome for family members – there are important mediating and moderating factors that shape the nature of the risk. Molina et al. (2010), for example, found that the relationship between density of familial alcohol problems and children's behavioral disinhibition was only significant when coupled with less effective parenting practices (e.g. lack of warmth, monitoring, consistent discipline). Discipline and monitoring also mediated the relationship between parent and child alcohol use in Latendresse et al.'s (2008) study of 4,731 adolescents in Finland. Conflict, both parent-child and marital, has been found to mediate the relationship between parental problem drinking and social and behavioural problems in children (El-Sheikh & Flanagan, 2001), and children's self-esteem is affected by parental alcohol use via its negative effects on family cohesion (Bijttebier & Goethals, 2006). These and a range of other studies suggest that it is the complex interaction between alcohol exposure and family process

which ultimately determines outcomes (El-Sheikh & Buckhalt, 2003; Kachadourian, Eiden, & Leonard, 2009; Keller, Cummings, & Davies, 2005; Keller, Cummings, Davies, & Mitchell, 2008). Regardless of the mechanism, the alcohol patient's contribution to family outcomes is well established. The reverse case, however – the family's contribution to alcohol outcomes – has been less thoroughly investigated.

### Predictors of alcohol treatment outcomes: The interpersonal dimension

The attempt to systematically identify reliable predictors of alcohol treatment outcomes has engaged researchers for over 50 years. The reasons for this sustained interest are many – identifying the predictors of treatment failure allows for better targeting of at-risk groups and the development of more effective interventions; it also makes estimations of prognosis more accurate (Adamson, Sellman, & Frampton, 2009). The best predictors of outcome – and those most researched – are largely individual factors, consistent with a treatment paradigm that has targeted patients outside of their social and relational contexts (Velleman, 2010). Severity of alcohol dependence (Adamson et al., 2009; Boschloo et al., 2012), the presence of comorbid psychiatric symptoms like anxiety or depression (Adamson et al., 2009; Boschloo et al., 2012; Kodl et al., 2008; Willinger et al., 2002), and cognitive factors such as alcohol-specific self-efficacy, motivation, and alcohol expectancies (Adamson et al., 2009; Bauer, Strik, & Moggi, 2014; Hendershot, Witkiewitz, George, & Marlatt, 2011; Ludwig, Tadayon-Manssuri, Strik, & Moggi, 2013; Witkiewitz & Marlatt, 2004) are some of the strongest predictors of relapse.

Interpersonal predictors of treatment outcome have been less well studied, though the ability of social factors to influence the individual relapse predictors above has been noted. Systemic conceptualisations of relapse describe how the relationship between interpersonal factors and outcome is mediated by these intrapersonal affective, cognitive

and behavioural processes (Hunter-Reel, McCrady, & Hildebrandt, 2009; Hunter-Reel, McCrady, Hildebrandt, & Epstein, 2010; Leach & Kranzler, 2013). In this context it becomes more understandable why marital events are among the most frequently cited relapse triggers, along with social pressures, interpersonal conflicts and family problems (Hammerbacher & Lyvers, 2006; Maisto, O'Farrell, Connors, McKay, & Pelcovits, 1988; Marlatt, 1996), even if relational factors account directly for only around 4.7% of the variance in treatment outcome (Beattie, 2001). It is easy to imagine how a powerful individual relapse predictor like negative affect may be driven by a contextual trigger (Hendershot et al., 2011). In fact, marital and family problems and negative affect are so interconnected that they loaded on the same factor in an analysis of relapse antecedents (Zywiak et al., 2006).

Research on interpersonal factors as direct predictors of outcome themselves has focused largely on social support. Belonging to a demographic category which implies social support – e.g. being married – consistently predicts improved outcomes (Adamson et al., 2009; Beattie, 2001; Boschloo et al., 2012; Walter et al., 2006). In one study, single alcohol inpatients were twice as likely to relapse as those in partnerships, regardless of gender, with the highest relapse risk seen among those recently separated from their partners (Walter et al., 2006). In another, the persistence of alcohol use disorder was 70% among recently divorced participants, compared to 23.5% among the newly married (Chilcoat & Breslau, 1996).

A meta-analysis on the topic of social support found that higher levels of general social support predicted more positive treatment outcomes, especially social support at pre-treatment and marital and family adjustment after treatment (Beattie, 2001). Importantly, however, researchers operationalising this construct more explicitly found that social

support was only predictive as far as it was alcohol-specific (Beattie & Longabaugh, 1997); in the long term, this alcohol-specific support mediated the relationship between general social support and treatment outcomes (Beattie & Longabaugh, 1999). Qualitative interviewing has confirmed the key role of alcohol-specific support in maintaining change post-treatment (Orford, Hodgson, et al., 2006), and a related construct, social network opposition to drinking, is predictive of more days abstinent and fewer heavy drinking days after discharge (Longabaugh, Wirtz, Zywiak, & O'Malley, 2010). Alcohol-specific social support during the treatment process also predicts better outcomes: in a study investigating involvement of concerned others in individual alcohol treatment, the 26.9% of participants whose relative or friend attended at least one of their behavioural skills training sessions had significantly fewer drinking days and alcohol-related problems after treatment (Hunter-Reel, Witkiewitz, & Zweben, 2012).

A small body of literature has been dedicated to understanding whether relational factors are more effective predictors of outcome for those more highly invested in their relational roles. Longabaugh et al. (1993) found that alcohol-specific social support predicted more positive drinking outcomes when present and worse drinking outcomes when absent in this population, while low investors were not affected either way. Relationship enhancement interventions also proved more effective than other methods for high investors with low systemic support for abstinence and the reverse (Longabaugh, Wirtz, Beattie, Noel, & Stout, 1995). A similar construct, systemic autonomy, was found to moderate outpatient treatment outcomes: patients with low autonomy from their families had fewer days abstinent post-discharge if family functioning had been impaired at intake (McKay, Longabaugh, Beattie, Maisto, & et al., 1992), and were more likely to improve if family functioning also improved during treatment (McKay, Longabaugh, Beattie, Maisto,



& Noel, 1993). Those with high autonomy from their families were not impacted by family functioning at intake or by family change across treatment. Together these studies support the idea that, when predicting relapse, there may be varying levels of vulnerability to relational factors. Notably, those with insecure attachment and/or low differentiation of self – subpopulations that, like low autonomy patients or high investors, are typically responsive to systemic factors – are overrepresented in the addiction treatment setting (Doumas, Blasey, & Mitchell, 2007; Sutherland, Cook, Stetina, & Hernandez, 2009; Thorberg & Lyvers, 2006).

### Relational interventions: Using the family to impact alcohol outcomes

While the literature on interpersonal predictors of alcohol outcomes does not extend much beyond the effects of social support, the extensive literature on the effectiveness of systemic interventions for alcohol misuse offers clear evidence for the potential of relational factors to influence treatment outcomes. In a systematic review of randomised controlled trials (RCTs) of family-based treatments conducted in the United States between 1996 and 2011, substance misuse disorders were the most thoroughly investigated mental health condition, with nearly three times as many RCTs conducted ( $n=23$ ) as for the next most studied condition (schizophrenia,  $n=8$ ) (Meis et al., 2013). These interventions, designed primarily to facilitate treatment entry or to reduce problematic substance use, have also shown promise in relapse prevention (Copello, Templeton, & Velleman, 2006; Meis et al., 2013).

Behavioural Couples Therapy (BCT), the subject of 16 RCTs, is not only the most well-studied systemic approach for substance misuse disorders, but the most investigated family intervention across all mental health conditions in Meis et al.'s systematic review (Meis et al., 2013). BCT uses cognitive behavioural strategies to maintain abstinence as

part of a “recovery contract” between the patient and his or her partner; at the same time, the couple work on enhancing their general relationship skills (Powers, Vedel, & Emmelkamp, 2008). BCT has consistently been shown to outperform individual therapies in controlled trials, with the additional benefit of improving relational outcomes (Meis et al., 2013; O’Farrell & Clements, 2012; Powers et al., 2008; Rowe, 2012). In a meta-analysis of 14 of the 16 RCTs, Meis et al. (2013) found that BCT increased the number of days abstinent at post-treatment, short and long-term follow-up compared to individual interventions, and that BCT participants had normal Dyadic Adjustment Scale (DAS) scores at the latter two points; those in individually focused treatment had DAS scores consistent with relational distress. The adoption of BCT has been recommended as best practice for alcohol patients with partners in the UK (NICE, 2011).

A twelve-month relapse prevention add-on to BCT was tested by O’Farrell and colleagues in 1998; the results highlight how relational and drinking outcomes are interconnected. The additional monthly sessions improved both drinking and marital outcomes in participants receiving them, but the strongest effect was found among alcohol patients with the lowest relational satisfaction (O’Farrell, Choquette, & Cutter, 1998). These patients maintained their improved drinking outcomes across the entire 30 month follow-up period while those with low relational satisfaction who did not receive the relapse prevention sessions had fewer abstinent days and saw a gradual return to drink across the same interval.

Social Behaviour and Network Therapy (SBNT) is another systemic treatment that has shown utility in substance misuse (Copello, Orford, Hodgson, Tober, & Barrett, 2002). Developed to test the efficacy of socially focused treatments against individually focused interventions in the UK Alcohol Treatment Trial (UKATT), SBNT helps alcohol patients

to engage or develop positive social support for abstinence. Family members, friends, and other concerned parties (e.g. neighbours, colleagues) are either included in the therapy or approached outside according to a plan developed between patient and therapist. SNBT significantly reduced alcohol consumption, alcohol-related problems, and severity of dependence in trial participants, and no differences in effectiveness were found between SBNT and Motivational Enhancement Therapy, an empirically validated, individually focused treatment (UKATT Research Team, 2005b).

When treatment engagement alone is the outcome measured, systemic support is a clear driver of change (Meis et al., 2013; O'Farrell & Clements, 2012; Rowe, 2012). In a review of 19 clinical trials testing 10 different approaches to family-driven treatment entry, Stanton (2004) found that the overall treatment engagement rate was 65%. This was significantly higher than standard family therapy, which still had a 52% treatment entry rate, self-help (17%) or no treatment (6%). Community Reinforcement and Family Training (CRAFT), a method which aims to bring substance dependent individuals to treatment by engaging and training their family members, was three times more effective than Al-Anon, which emphasises the family's powerlessness, in facilitating treatment entry (Meis et al., 2013). O'Farrell and colleagues found that a simple one session family intervention following inpatient alcohol detoxification resulted in 92% of patients engaging with continuing care, compared to 62% of those whose families were not involved in aftercare planning (O'Farrell, Murphy, Alter, & Fals-Stewart, 2008). Interventions like these show how the family's active support for treatment can be used to engage this difficult to reach population. This idea is consistent with patients' own reports of the factors which motivated them to seek treatment: pressure from family members was a key driver for participants in the UK Alcohol Treatment Trial (Orford, Kerr, et al., 2006),

and in a study by Marlowe et al. (2001), the largest cluster of substance misuse patients cited family support or pressure as the primary instigator of treatment.

Consistent with a systemic formulation of alcohol misuse, interventions aimed at improving family members' outcomes have demonstrated knock-on effects on their alcohol dependent relatives as well (Copello, Templeton, Orford, & Velleman, 2010a). The 5-Step Method for affected family members focuses on improving coping strategies and social support among adult relatives of substance dependent persons, with outcomes focused on the physical and psychological well-being of the family members themselves (Copello, Templeton, et al., 2010a; Copello, Templeton, Orford, & Velleman, 2010b). Both the full five session intervention and a brief one session version were equally effective at reducing family members' symptoms at 12 week and 12 month follow-up, but participants also reported a continual, statistically significant improvement in their relative's substance use across this interval (Velleman et al., 2011). As neither substance use nor the substance dependent member were targeted by this intervention, this finding shows how change in one area of the system (i.e. amongst family members) can be sufficient to instigate change elsewhere (i.e. in the alcohol dependent member).

#### Alcohol dependence and recovery: Relational models

While alcohol research with a systemic focus is a relatively recent development, theoretical models of alcohol dependence and the family have a longer history. The development of Alcoholics Anonymous in the 1930s grew out of a new understanding of the influence of social context on drinking behaviour, and by the 1950s the impact of family relationships began to be examined. Early systemic conceptualisations principally pathologised the wives of alcohol dependent husbands for choosing men that would satisfy their own psychological needs; the prediction that these wives would be destabilised as a

result of their husbands' abstinence was the first suggestion that family factors might play a maintaining role in alcohol misuse (Whalen, 1953). The first truly bidirectional systemic conceptualisation, however, was the work of Jackson (1958). In her view, family functioning and individual development were affected by alcohol misuse at the same time as the family's influence served to shorten or prolong the course of the addiction.

The next major step in the evolution of systemic thinking about alcohol and the family came 20 years later with Steinglass's Life History Model (Steinglass, 1980; Steinglass, Davis, & Berenson, 1977). Steinglass described how the family's interactional patterns became organised around alcohol misuse, limiting available behavioural responses and leading ultimately to a state of developmental paralysis. Abstinence was seen as a risk to the family's homeostasis and a trigger for destabilisation, thus unwittingly locking the family into maintaining the addiction in order to protect its systemic balance. Brown and Lewis's later Family Recovery Model built on these ideas, emphasising that families could resume normal development by making recovery, rather than alcohol, the primary organising principle of the system (Brown & Lewis, 1999). In this model, family members were encouraged to detach from one another and pursue their own individual recovery programmes until a new way of relating could be established.

More recent authors have been critical of the above models for blaming or implying codependency or pathology in family members. The stress-strain-coping-support model by Orford and colleagues acknowledges the centrality of alcohol in the lives of these families while challenging the idea that family members are responsible for maintaining a relative's addiction (Orford, Copello, et al., 2010). The authors describe life in proximity to alcohol misuse as a highly stressful situation which family members attempt to cope with to the best of their ability. Mutuality of influence between the alcohol dependent relative and the

family is assumed; family members' ability to promote change – for themselves and their substance dependent relative – is acknowledged and encouraged.

Theoretical models like these provide further impetus for considering the value of family factors as potential predictors of outcome. Given the connectedness these models assume between the alcohol patient and his or her system, the state of family relationships at point of treatment is relevant and likely to directly or indirectly influence its outcome. No research to date has examined this moment of transition prospectively in a residential setting, so our understanding of what happens in the family at the moment when alcohol and the alcohol dependent member are removed is incomplete. Changes in the family during this period might, however, be inferred by reviewing the research on other wet-to-dry transitions.

#### The “Sobriety-Intoxication Cycle:” How alcohol affects short-term family process

Research has shown that families with an alcohol dependent member have distinct sets of behaviour in wet versus dry phases that can be meaningfully and statistically discriminated from one another. In describing the sobriety-intoxication cycle, Steinglass explained that family behaviour during intoxication can be just as predictable as it is during sobriety (Steinglass et al., 1987). He theorised that families draw benefit from the specific behavioural response sets available to them in wet phases, thereby strengthening the hold of the addiction. In a series of case studies in the late 1970s, Steinglass found that problem-solving behaviour was enabled in periods of intoxication (Steinglass et al., 1977). Other authors have replicated this finding (Frankenstein, Hay, & Nathan, 1985; Jacob & Leonard, 1988; Leonard & Roberts, 1998), as well as documenting improvements in interactional positivity. Wives in one study displayed twice as much positive verbal behaviour while their husbands were intoxicated (Frankenstein et al., 1985), while in

another, alcohol dependent wives' negativity decreased to the level of controls when given access to alcohol (Haber & Jacob, 1997). Thus, for some families, there is evidence of adaptive interpersonal behaviour in wet phases that is not evident in dry phases (Marshall, 2003).

Other studies, while still supporting the biphasic nature of behaviour in these families, have found improved functioning in dry phases. Jacob, Ritchey, Cvitkovic and Blane (1981) provided subjects with alcohol to assess communication differences between wet and dry conditions in real time; they found that negative affect increased with intoxication, and partners were more likely to express disagreement. This finding was replicated later by Leonard and Roberts (1998). All 23 of the families interviewed in Haughland's (2005) study reported deterioration in family routines and rituals in wet phases, driven largely by the alcohol dependent individual's disengagement from parenting.

Many studies, however, have been unable to find consistent directional differences across families, despite the presence of distinct responses to wet and dry phases. In Liepman et al. (1989), couples reported significantly better functioning in dry phases, but 17 of the 20 couples indicated that their functioning was better in the wet condition in at least one area (Liepman, Flachier, & Tareen, 2008). Seilhamer and colleagues found a significant relationship between parents' daily alcohol consumption and children's relational satisfaction for the majority of dyads tested – but in half the effect was positive and in the other half, it was negative (Seilhamer, Jacob, & Dunn, 1993).

The overall inconsistency of the findings in this area has led other authors to investigate the sobriety-intoxication cycle in specific subgroups in an attempt to identify predictable effects. Dunn and colleagues found that while alcohol consumption was

negatively related to marital satisfaction in all couples where the dependent individual primarily drank outside the home, there was a positive relationship between consumption and the wife's marital satisfaction for most couples where the husband drank in the home (Dunn, Jacob, Hummon, & Seilhamer, 1987). Jacob and Leonard (1988) found that problem-solving behaviour increased in the drink condition among couples where alcohol misuse was consistent, but decreased among couples with a binge drinking pattern. In a later study, Jacob et al. found that intoxication had very little effect on the behaviour of couples where the alcohol dependent member scored low on antisociality. Where they scored high on antisociality, however, couples displayed a significant increase in negativity when drinking and a specific method for coping with it: wives used problem-solving behaviour to manage their husbands' negativity in the dry condition and husbands took on this role when drinking (Jacob, Leonard, & Haber, 2001). There is also evidence to suggest that couples in which both partners are heavy drinkers have more positive patterns of interaction than couples discordant for alcohol use (Leonard & Eiden, 2007).

In summary, the above studies repeatedly show that fluctuations in drinking are predictive of behaviour in the family context, though the exact nature of the response varies. That said, there are those who have failed to find biphasic patterns (Billings, Kessler, Gomberg, & Weiner, 1979), those that include a transitional phase and advocate a polyphasic model (Haugland, 2005), and the studies are somewhat dated and not without their methodological issues. Sample sizes were often extremely small (e.g. Dunn et al., 1987; Frankenstein et al., 1985; Jacob et al., 1981; Seilhamer et al., 1993), questionnaires retrospectively administered (e.g. Liepman et al., 1989), and in studies inducing intoxication, quantity consumed was less than participants would drink normally (e.g. Frankenstein et al., 1985; Steinglass et al., 1977). Despite this, however, the evidence



suggests that the family is responsive to short-term changes in drinking behaviour, and we can assume that when the alcohol dependent member attempts to transition from wet to dry permanently, there will be reverberations within the family context. In some families, losing part of an already limited behavioural repertoire may result in deterioration, even as improvements are apparent in other families (Liepman et al., 2008).

### Relapse and recovery: Longer-term changes in drinking patterns

Long-term outcome studies provide another vantage point from which to observe the impact of changes in drinking behaviour on the family. The seminal studies in this area were conducted using a sample of former alcohol inpatients two years post-discharge (Moos & Billings, 1982; Moos & Moos, 1984). Crucially, they found that in terms of both family functioning and children's emotional well-being, recovered families did not differ significantly from controls. Relapsed families, however, displayed less cohesion, expressiveness and recreational orientation than either of the other groups (Moos & Moos, 1984), and children in these families had more psychological symptoms and somatisation (Moos & Billings, 1982). Later authors also found differences between families in recovery and those who returned to drinking. Andreas and colleagues found that children whose fathers remained abstinent after treatment did not differ from controls in terms of their psychosocial adjustment a year later, while those whose fathers had relapsed were eight times as likely to exhibit clinical-level symptoms (Andreas, O'Farrell, & Fals-Stewart, 2006). In another study, children's exposure to parental conflict decreased to the level of a comparison sample six months post-treatment (Rounsaville, O'Farrell, Andreas, Murphy, & Murphy, 2014). Weisner et al. (2010) found that family members' excess healthcare costs returned to average levels if their alcohol dependent relative achieved abstinence; their health spending was equivalent to controls' in the five years after

treatment, while the relatives of those who had relapsed saw an increase in health costs. Taken together, these findings imply that families that successfully navigate alcohol treatment have the potential to resume normative functioning in time, though they say little about the immediate effects of the shift away from active drinking or about which families relapse and which recover.

Several other studies also attest to improvements in child symptomology after a parent's alcohol treatment, though they do not include comparison with a control group. Andreas & O'Farrell found that children's internalising and externalising behaviours varied predictably by their fathers' post-treatment alcohol consumption – those whose fathers reliably maintained abstinence saw a steady decline in child maladjustment from pre-treatment to 12 month follow-up, while the reverse was true for children of parents who returned to drinking (Andreas & O'Farrell, 2007). In a later study by the same authors, greater parental treatment involvement and subsequent abstinence were associated with lower levels of externalising problems in children (Andreas & O'Farrell, 2009). Arria and colleagues found that a father having been in treatment alone reduced the risk of substance misuse in his offspring, even without considering treatment outcome (Arria et al., 2012).

Studies undertaken with community samples rather than clinical populations have been less positive about the long-term effects of recovery on the family. In these studies, adolescent children of recovered fathers displayed more internalising and externalising symptoms than controls and were more similar to children in homes with active drinking (DeLucia, Belz, & Chassin, 2001; Puttler, Wong, Fitzgerald, & Zucker, 2004); they were also more likely to engage in addictive behaviour if a parent had done so, regardless of whether the parent was in recovery (Pidcock & Fischer, 1999).

It is worth noting that some studies have found a moderating effect of development when considering the impact of parental recovery on child functioning. Differences between children in control and recovered families were eliminated when recovery had taken place either before the child was born (Puttler et al., 2004) or before the child's sixth birthday (Moss, Clark, & Kirisci, 1997). DeLucia et al.'s (2001) concept of functional autonomy – the idea that symptoms arising from familial alcoholism eventually become self-reinforcing – may help explain this finding; it suggests that, in some families, recovery alone may not be enough to modify outcomes for children with long exposure to alcohol misuse.

In summary then, the above studies suggest that although there are precedents for resuming normative functioning in both theory (Brown & Lewis, 1999) and practice (Andreas et al., 2006; Moos & Billings, 1982; Moos & Moos, 1984; Weisner et al., 2010), not all families thrive in recovery. Understanding how the family responds during the transition to sobriety might help to improve not only treatment outcomes, but family outcomes as well.

## Conclusions

A review of the literature finds evidence from both research and theory to support a reciprocal relationship between an alcohol dependent individual and his or her family. Family members' health and well-being are affected by their proximity to alcohol misuse, both directly and through the mediating effects of family process. The mechanisms by which family factors impact alcohol outcomes are less clear, although the literature on social support, the evidence base for systemic interventions and an evolving catalogue of theoretical models all strongly suggest their influence. Study 1, which examines whether

the state of family relationships at point of treatment is associated with patient outcome, aims to contribute to this dialogue and is introduced in the next chapter.

How the family itself changes during the rehabilitation process has not been investigated prospectively in a residential treatment setting. The only comparable piece of research was a 1993 study of alcohol outpatients which found that while family functioning improved from intake to six-month follow-up in the sample as a whole, deterioration across this period predicted poorer treatment outcomes among patients scoring low on autonomy (McKay et al., 1993). This is a different scenario than that being investigated in this thesis: outpatient treatment is systemically not as disruptive since the family is left intact throughout, and the patients themselves are not as severely dependent as those who enter structured residential programmes. The finding, however, does support the hypothesis that families will respond to alcohol treatment in their own right, joining the range of studies described above on other wet-to-dry transitions which provide evidence of a systemic reaction to changes in alcohol use. Study 1 and Study 2 will investigate changes in the family during this crucial transition using both qualitative and quantitative methods; understanding family process at this point is key if we are to give patients and their families the best chance at recovery.

## Chapter Three: Study 1 – Methodology & Results

### Aims

As described in the literature review in Chapter Two, the impact of family relationships on alcohol misusers and their outcomes is less clearly evidenced than the reverse case. Study 1 was designed with this in mind, and takes as its primary aim to investigate whether the state of family relationships at treatment entry is associated with or predictive of patient outcome. No studies have examined this question in a residential treatment context, reserved for the most severely dependent alcohol patients. As discussed in the introduction, knowing what aspects of family life contribute to or compromise recovery capital is crucial at point of treatment.

A secondary aim of this study is to examine family change across the rehabilitation process: whether changes occur in family relationships during this period, and whether any such changes are consistent across families. Previous research has shown that the family is responsive to changes in addictive behaviour, but no studies have examined family process prospectively in a residential setting.

### Hypotheses

In line with the first aim of the study, the primary hypothesis under investigation is the recovery capital hypothesis. In the introduction, recovery capital was defined as “the sum total of one’s resources that can be brought to bear on the initiation and maintenance of substance misuse cessation” (Cloud & Granfield, 2008, p. 1983). Given the connectedness of the alcohol patient and his or her family evidenced by both research and theory, one would expect the character of a patient’s family relationships to impact upon their available recovery capital at point of treatment. The more functional and satisfying

family relationships are, the more resources an individual patient can be said to have available for recovery. Thus, it can be hypothesised that key family functioning variables will be associated with, and even predictive of, treatment outcome. The healthier these family relationships are perceived to be by the patient, the more likely the patient will be to complete treatment. 'Healthy' functioning will be indicated by higher levels of flexibility, cohesion, communication and satisfaction, lower levels of conflict, and less endorsement of the extremes of flexibility (rigidity/chaos) and cohesion (enmeshment/disengagement).

The secondary hypothesis for the study concerns family change. Given the responsivity of families to changes in alcohol use and the interconnectedness of family and patient, it can be hypothesised that participants will report changes in family life across the residential rehabilitation process. Change will be defined as an improvement or deterioration in functioning from baseline, and will be operationalised in terms of the family's flexibility, cohesion, communication, and conflict and patients' reported satisfaction with family life. In families whose functioning improves, questionnaire measures will reflect one or more of the following over the period of study: a movement *away from* the extremes of flexibility (lower rigidity/chaos scores) or cohesion (lower enmeshment/disengagement scores), less reported conflict, more positively rated communication, and/or increased patient satisfaction. In contrast, families whose functioning deteriorates will demonstrate one or more of the following: a movement *toward* the extremes of flexibility (higher rigidity/chaos scores) or cohesion (higher enmeshment/disengagement scores), more reported conflict, more poorly rated communication and/or less patient satisfaction with family life. It is not anticipated that all families will change in a consistent direction.

## Design

This thesis utilises a mixed methods design. Study 1, the quantitative component, was a longitudinal prospective cohort study following alcohol inpatients through the rehabilitation process. Assessment took place at three time points – during initial detoxification, in the final month of residential rehabilitation and at one-month follow-up. This design allowed the relationship between baseline family functioning variables and outcome to be investigated, while also permitting the observation of changes in key family variables in cases where participants remained in treatment – and in the study – at all three time points. In the following sections, the study will be described from its organisation through its execution and analysis.

## Recruitment of partner organisations

As the current project was not associated with an existing programme of research, alcohol treatment centres willing to act as study sites had to be identified before participant recruitment could begin. Due to the increasing fragmentation of alcohol services – the closure of dedicated NHS inpatient units, the move towards private and voluntary sector care, and the severance of the traditional detoxification-to-rehabilitation care pathway – recruiting partner organisations was difficult, and a greater and more diverse number of partners were needed to ensure access to a sufficient sample of alcohol patients. Heads of primarily London-based detoxification and rehabilitation services in the NHS, private and voluntary sectors were approached and meetings were conducted with management-level contacts. Eleven study sites across 8 organisational partners were established, covering a range of alcohol treatment services currently provided in the UK (see Table 3.1). The detoxification centres were the site of recruitment for Study 1, and the rehabilitation centres the site of recruitment for Study 2.

Table 3.1: Anonymised summary of study sites

| <b>Residential detoxification centres</b>   | <b>Residential rehabilitation centres</b>   |
|---|---|
| <b>NHS</b>  | <b>Private sector</b>   |
| 1. Detoxification Centre A, Partner 1<br>2. Detoxification Centre B, Partner 2  | 1. Rehabilitation Centre A, Partner 6<br>2. Rehabilitation Centre B, Partner 7<br>3. Rehabilitation Centre C, Partner 8 |
| <b>Voluntary sector</b>   | <b>Voluntary sector</b>   |
| 1. Detoxification Centre C, Partner 3<br>2. Detoxification Centre D, Partner 4<br>3. Detoxification Centre E, Partner 5 | 1. Rehabilitation Centre D, Partner 4<br>2. Rehabilitation Centre E, Partner 4<br>3. Rehabilitation Centre F, Partner 7 |

Once host organisations were committed to the project, it was necessary to establish a working team inside each service to facilitate participant recruitment. Meetings were held with care workers, admissions coordinators and psychologists/psychiatrists in order to find the most appropriate people to encourage participant enrolment at each site; in the process, most people in patient-facing roles at the host organisations were made aware of the project. As procedures for patient care varied, recruitment protocols were customised for each service (see section below).

### Recruitment of participants

In Study 1, participants were recruited at intake for residential detoxification subject to the following inclusion criteria: 1) alcohol was the primary substance for which the patient was seeking treatment, 2) the patient had a partner, child, or lived with / was supported by another family member, and 3) was going on to residential rehabilitation after detoxification. Patients' need for a residential detoxification established the presence of severe alcohol dependence in the study population (NICE, 2011). Patients were excluded from participation if they had a diagnosis of psychosis or were cognitively impaired to the point that they could not give informed consent. Polydrug use was common and drug users were not excluded so long as alcohol was the primary problem.



At NHS sites, staff preferred to identify participants at the referral stage and approach suitable candidates themselves. When a new referral met the inclusion criteria, the patient was given the participant information sheet (see Appendix 1) by their care worker or admissions personnel and were offered a telephone call with the researcher to discuss any questions they had before enrolling in the study. The researcher contacted NHS sites weekly to enquire after potential participants.

At voluntary sector sites, the researcher presented the study directly to residents of the detoxification centres each week before a house meeting. As the sites had between 16 (Detoxification Centre D) and 27 beds (Detoxification Centre C), these were the maximum audiences for each weekly presentation. Interested parties were asked to speak to the researcher privately after the meeting, where they were given information sheets and appointments to participate if they met the inclusion criteria. On average, one participant per week was enrolled in the study this way. Patients were incentivised to take part by being told they would be entered into a lottery to win one of three retail vouchers (£70, £20, £10) if they participated at all three time points.

Although 5 detoxification centres agreed to take part in the study, approximately 55% of participants for Study 1 came from Detoxification Centre C and 44% came from Detoxification Centre D. This means that all but one participant came from the voluntary sector. This reflects the current state of alcohol treatment in England: with the shift to local authority control discussed in Chapter One, contracts are increasingly being awarded to voluntary sector sites rather than to more costly and increasingly limited NHS inpatient services. In the NHS setting, hardly anyone met the inclusion criteria for the study – cases were more complex and service users less likely to be in contact with their families. The recruitment strategy at these sites was also less effective. The researcher was not allowed

to recruit the population directly, and the referrals that staff screened lacked detailed information about patients' family situations.

No recruitment came from Detoxification Centre E, the other voluntary sector site, due to its late addition to the study and its higher proportion of drug to alcohol users.

### Measure selection

In order to select the most appropriate assessment tools for the study, a review of measures of individual and relational functioning was undertaken. The chosen measures and the rationale for their selection appear below. Four sample items from each measure can be found in Appendix 7.

*Alcohol assessment battery:* In order to measure severity and frequency of alcohol consumption, this study adopted the methodology utilised by the two largest trials of alcohol treatment to date – the UK Alcohol Treatment Trial (UKATT Research Team, 2005b) and Project MATCH (Project Match Research Group, 1997). These trials used the Timeline Followback interview method (Sobell & Sobell, 1992) to calculate two key consumption variables – percent days abstinent (PDA) and drinks per drinking day (DDD). In order to control for baseline alcohol dependence, a variable strongly predictive of relapse, the Severity of Alcohol Dependence Questionnaire (SADQ; Stockwell et al., 1994) was administered. This measure is recommended by NICE and used by the health service to assess physical and psychological indicators of withdrawal and to make treatment decisions (NICE, 2011). The Alcohol Problems Questionnaire (APQ; Drummond, 1990), also recommended by NICE, was chosen as a repeat measure to assess the global level of alcohol-related improvement – an outcome arguably more relevant to families than simple change in consumption. Those with current partners were asked to answer four questions from the Important People Interview (IPI; Longabaugh et al., 2010)

regarding their partner's level of drug or alcohol use, tolerance of the patient's drinking, and support for abstinence in order to gauge the level of alcohol-related social support available in participants' intimate relationships.

*Hopkins Symptom Checklist 25 (HSCL-25; Hesbacher, Rickels, Morris, Newman, & Rosenfeld, 1980):* Adamson et al. (2009) found that continuous measures of psychopathology were twice as likely to predict alcohol outcomes as individual measures of anxiety or depression; thus, the Hopkins Symptom Checklist 25, a shortened version of the gold standard Symptom Checklist 90, was chosen to assess individual psychological functioning. In a comparison of 11 abbreviated versions of the Symptom Checklist 90, the HSCL-25 was recommended for its internal consistency, strong correlations with the original and related measures, and its superior ability to discriminate between subjects (Müller, Postert, Beyer, Furniss, & Achtergarde, 2009). Psychological symptoms strongly predict relapse and were measured so as to control for them in the overall model.

*Family Adaptability and Cohesion Scale IV (FACES-IV package; Olson, 2011):* It was important when operationalising family functioning to choose assessment tools that were theoretically compatible with the systemic ideas that inform this project. The FACES family of measures is built on the Circumplex Model of Marital and Family Systems, and more than 250 studies using the measures have supported the model's assumptions (Lebow & Stroud, 2012; Olson & Gorall, 2003). Organised along two dimensions, cohesion and flexibility, the circumplex model asserts that the healthiest families will be those which avoid the extreme ends of either dimension. Cohesion, ranging from disengaged to enmeshed, describes how families manage distance. Flexibility, ranging from rigid to chaotic, describes how families negotiate change. Together, they illustrate how families respond to challenges systemically. FACES is the third most used family measure in the

literature (Sanderson et al., 2009) and the factor structure, validity and reliability of the instrument have been shown to be sound (Olson, 2011). The instrument consists of 4 subscales which measure the extremes of cohesion (disengaged and enmeshed) and flexibility (rigid and chaotic), as well as 2 subscales assessing balanced functioning on each dimension. Cohesion and flexibility ratios are then derived which describe the degree of functional versus dysfunctional behaviour in the system. The package also includes the Family Communication Scale and the Family Satisfaction Scale, both of which have been used in the study.

*Family Environment Scale* (FES; Moos & Moos, 2009): The FES is the second most used family measure in the literature, employed in over 500 studies (Lebow & Stroud, 2012; Sanderson et al., 2009). This study used only the conflict subscale, which has shown good internal consistency and convergent validity in a sample of families dealing with alcohol misuse, and is one of six FES subscales whose factor structure performed as expected on analysis (Sanford, Bingham, & Zucker, 1999).

*Experiences in Close Relationships Revised scale* (ECR-R; Fraley, Waller, & Brennan, 2000): Because previous studies have found the relationship between family functioning and outcome to be moderated by how highly invested alcohol patients are in these relationships, two related variables – attachment-related anxiety and avoidance – were assessed in patients with current partners. Operationalising attachment as relationship-specific increases the variable's clinical relevance and is consistent with recent thinking in the field, which is moving away from fixed, trait-based models of attachment (Fraley, Heffernan, Vicary, & Brumbaugh, 2011). Relationship-specific measures are better predictors of intra- and interpersonal outcomes than general attachment measures because of their potential to change longitudinally (Fraley et al., 2011). The ECR-R is

specifically recommended for detecting subtle attachment changes due to its excellent test-retest reliability (Sibley, Fischer, & Liu, 2005; Sibley & Liu, 2004).

## Procedure

*Time one.* As the initial detoxification phase of treatment lasted on average for only 13.5 days (range 7-28 days), participants who agreed to take part in the study were given an appointment for a research session within a few days of enrolment. Sessions typically took 45 minutes to 1 hour to complete and began with informed consent (see Appendix 2), followed by a baseline alcohol assessment and a questionnaire battery.

The baseline alcohol assessment began by measuring the frequency and severity of pre-admission alcohol consumption using the Timeline Follow-back interview method (Sobell & Sobell, 1992), which yielded self-report data for the 30 days prior to treatment entry. The author was trained to use the method and conducted four practice interviews with volunteer alcohol inpatients at one of the research sites in order to ensure competence in administration. Patients were first asked to report chronologically what they had consumed the day before entering detoxification, and to be specific about the amount and type/brand of alcohol consumed. To ascertain an average day's consumption, they were then asked how this had differed from the norm, and to describe episodes in the previous month in which they drank significantly more or less than this average or had abstained altogether. Patterns of consumption were established; to aid memory, participants were prompted to consider holidays, birthdays, paydays and other significant life events. Other drug use was assessed concurrently to verify that alcohol was the primary concern, and to distinguish polydrug users from those who used only alcohol. The alcohol assessment ended with the SADQ, the APQ, and the abbreviated IPI, all described above.

The primary questionnaire battery was administered after the alcohol assessment to evaluate individual and relational functioning and included the following measures:

- (1) The HSCL-25, with its depression and anxiety subscales, to assess individual psychological functioning
- (2) The six subscales of the FACES-IV package to measure family functioning, specifically flexibility, cohesion and their extremes (rigidity, chaos, enmeshment and disengagement)
- (3) The conflict subscale of the Family Environment Scale, to capture this important component of family functioning not assessed by FACES-IV
- (4) The FACES Family Communication Scale and Family Satisfaction Scale, measures which both focus on the respondent's perception of the quality of their family relationships
- (5) The Experiences in Close Relationships Revised scale to evaluate the role of attachment anxiety and avoidance as possible moderators of the relationship between family functioning and outcome (only for those participants currently in relationships, whether estranged or intact)

Demographic information was also recorded in order to describe the sample and control for other potential predictors of outcome (e.g. gender, age).

At the end of the session, participants consented to be contacted on their home and mobile telephones, via email, at their residential rehabilitation centres and home addresses, as well as through two named "locators" (e.g. a partner, parent or key worker). This system for locating participants was designed to minimise loss to follow up, ensuring at the very least that treatment completion outcomes were available for each participant.

*Time two.* At the beginning of each participant's final month of residential rehabilitation, the researcher contacted them to verify they were still in treatment. If so,

the questionnaire battery described in numbers 1-5 above was then re-administered by post. Participants were asked to complete it before they finished their rehabilitation programme and to return it using a postage paid envelope included in the package. Their post-discharge contact details were verified. If questionnaires were not returned, participants were reminded by phone in the 10 days leading up to discharge. If participants were no longer in treatment at time two follow-up, admissions staff at the rehabilitation centre were asked to confirm the date and circumstances of termination.

*Time three.* All patients who were still in treatment at time two, whether or not they returned their questionnaires, were contacted one month after their planned completion date using the home or mobile telephone numbers provided at intake and confirmed at follow-up. Patients who were responsive to researcher contact were asked to confirm that they had completed their rehabilitation programme as expected, and to update the researcher on the progress of their recovery. They were then re-administered the questionnaire battery a final time by post, with the addition of a repeat measure of the APQ from the initial alcohol assessment to gauge the continuation of alcohol-related problems. Participants who did not return the questionnaires were reminded 2-3 weeks later by telephone. Some participants needed two or more calls before questionnaires were completed.

Where it was not possible to contact participants at time three, admissions staff at their rehabilitation centre were contacted to confirm whether the participants had completed their programme as expected. This ensured that treatment completion outcomes were available for all participants even if the participants themselves were lost to follow-up. If they had completed treatment, forwarding information was compared against programme records to make sure contact details were correct. If they were correct and

participants still could not be reached, the participant's identified locators were contacted to help the researcher reach the participant. Newly discharged patients frequently changed their mobile phone numbers in an effort to distance themselves from their previous lives, and finding even successfully discharged patients often took considerable effort.

### Data analysis strategy and sample size

In order to test the primary hypothesis – that healthier family functioning at intake would predict better treatment outcomes – Study 1 was originally powered to detect a medium effect size of .15 at 80% power using a multiple regression model ( $R^2$  increase). Calculations were done using G\*Power software (Faul, Erdfelder, Buchner, & Lang, 2009). Assuming five of the predictors entered into the model reached significance, a sample size of 55 alcohol patients was required. In order to account for anticipated attrition, the project was over-recruited by close to 25% ( $n=68$ ). In the event, attrition was low (9%) and the sample larger than required for this statistical test.

As data collection progressed, however, it became apparent that choosing a continuous measure of outcome (e.g. change in alcohol consumption) would not be the best use of the data. Collecting post-discharge or post-drop-out alcohol consumption was inaccurate to impossible, leaving many participants potentially without outcome data and thus excluded from the analysis. As Public Health England uses treatment completion rates to make its commissioning decisions (Public Health England, 2014b), it was decided to use this dichotomous outcome instead. This meant that the study needed to be powered to conduct a logistic rather than a linear regression. Based on the work of Peduzzi et al. (1996), sample size for logistic regression is generally considered adequate if there are 10 outcome events per predictor variable (EPV). To be more conservative, the smaller of the binary outcomes is taken as the “outcome event.” Recently other authors have suggested



that 10 EPV is an unnecessarily high threshold for logistic regression, finding that 5-9 EPV was problematic in less than 7% of cases (Vittinghoff & McCulloch, 2007). The current study sample then allows for a logistic regression with three predictors to be safely conducted according to Peduzzi's criteria, with additional predictors decreasing the EPV and potentially the reliability of the result accordingly.

At intake, higher levels of flexibility, cohesion, communication and satisfaction, lower levels of conflict, and less endorsement of the extremes of flexibility (rigidity/chaos) and cohesion (enmeshment/disengagement) were expected to be associated with successful completion of a patient's funded treatment stay. It was anticipated, however, that alongside powerful covariates like alcohol consumption/dependency and psychological symptomology, not all of these variables would explain enough additional variance to remain significant as predictors in a logistic regression model. To begin with then, a series of two-tailed independent samples t-tests were run to confirm between group differences, identifying significant relationships between baseline family functioning and treatment completion, in order to choose a specific set of variables to include in an initial logistic regression model. After running this model, the most strongly predictive variables were then used to create a smaller, more powerful model with a higher EPV.

Finally, in order to evaluate the utility of considering attachment variables as moderators of outcome, a secondary analysis was undertaken in a subsample of patients in current relationships. Two-tailed independent samples t-tests were used to identify significant differences in family functioning between groups high and low on attachment anxiety and avoidance, and the attachment variable most strongly associated with differences in family functioning was added to the final logistic regression model above alongside an interaction term.

In order to test the second hypothesis – that families would change across the residential rehabilitation process – a series of linear mixed models was run using the data from a subsample of treatment completers (n=32). Each model attempted to predict change longitudinally in one of the family functioning variables. Time was entered as a fixed effect and subject as a random effect. Linear mixed models are robust in the face of missing data, provided those data are missing at random, and account for within subjects correlations resulting from repeated measures. As missing data in this subsample of completers was a function of time (an observed variable already accounted for in the model) and not dependent on the unobserved values of the variables themselves, data were considered missing at random for statistical purposes.

Where time was statistically significant as a main effect, change was detected in a consistent direction across the sample for the specific family functioning variable tested. Where no such global effects were identified, graphical presentations of the data were examined to explore the possibility that changes in family functioning might be occurring for individual patients in a variety of directions.

#### Ethics and R&D approvals

The project was reviewed by the South East London Research Ethics Committee and received a favourable opinion on 29 May 2013; R&D approvals were in place for all relevant NHS trusts. The project was amended twice on account of design changes (substantial amendments approved on 15 July 2013 and 7 December 2013).

The primary ethical concern for Study 1 was that asking participants to think about or discuss the effects of alcohol on their families might be a distressing experience. This risk was attenuated by the fact that the majority of the study took place while participants were within a supportive service setting; additionally the researcher was a qualified family

therapist and able to manage the need for psychological support in real time when necessary. Study participants were given the researcher's contact details in order to enquire about further support once their research involvement had ended; this happened in two cases and these participants were referred to appropriate services.

The other key ethical issue raised by the committee in response to the original application concerned the management of potential disclosures. Given the nature of the topic, it was possible that abuse or neglect may have been disclosed during data collection. Consent forms and information sheets made the limits of confidentiality explicit, and relevant disclosures were to be reported in line with the child or vulnerable adult protection procedures of each host organisation. In the event, no such disclosures took place.

As recruitment and data collection proceeded, changes were made to the original study design which resulted in substantial amendments to the research protocol. These changes became necessary when aspects of the study design proved incompatible with the reality of the treatment context, and prevented the study from moving forward. As such, these changes are an interesting window into the reality of alcohol treatment today.

The first major change was to the inclusion criteria. The original study was designed around the concept of the nuclear family, and patients were required to have partners and at least one child to participate. It very quickly became apparent that the nuclear family was the exception rather than the rule among severely dependent alcohol patients funded for a residential stay, and the inclusion criteria were broadened to include a wide variety of family formations. Thus, the study sample includes participants whose primary family ties were to parents or siblings, divorced or separated partnerships, childless couples and single parents.

The second major change also concerned the sample, in that originally data was to be collected from both patients and their partners. The fact that many potential participants did not have partners was obviously a limiting factor, but the primary and overwhelming constraint to collecting paired data was the lack of access to partners in the treatment context. This reflects the individually focused model of treatment that dominates alcohol services, especially in the initial detoxification phase when recruitment to the study took place. The recruitment strategy was broadened several times to try to access partners in different ways (e.g. at point of referral, through staff at intake) but in the end there was simply no formal involvement of partners at any point early in the care pathway that allowed them to be recruited independently of patients. Relying on patients to pass information about the study on to their partners was not successful in a single instance. In consequence, the data obtained in Study 1 reflects only patients' perspectives and must be interpreted with this in mind.

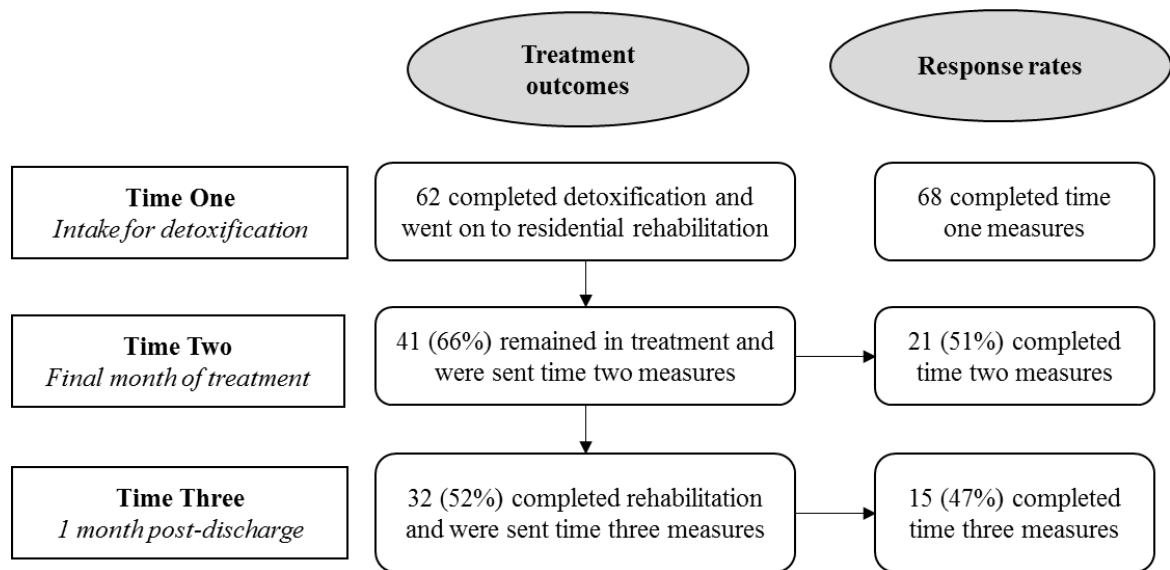
The final major change to the protocol was to incentivise participation by instituting a prize draw for those participants who completed questionnaires at all three time points, a practice widely used in addictions research.

### [Sample characteristics](#)

Sixty-eight participants completed the baseline alcohol assessment and initial questionnaire battery. Of these, 2 dropped out of the study during follow-up, 2 decided to go on to day programmes instead of residential rehabilitation, 1 returned home after detoxification, and 1 did not complete detoxification at all. This left a total sample size of 62 participants for Study 1, all of whom completed detoxification and entered residential rehabilitation programmes. At time two follow-up, 41 participants (66%) were still in treatment, of which 21 (51%) returned the second questionnaire battery. At final follow-

up, 32 participants (52%) had successfully completed their rehabilitation programmes and 15 (47%) of these returned the final measures. Fourteen participants completed questionnaires at all three time points. See Figure 3.1 below for a summary of treatment outcomes and response rates.

Figure 3.1: Flowchart of treatment outcomes and response rates for Study 1



The demographic characteristics of the sample are shown in Table 3.2 below. The sample very closely approximates the situation nationally, where, according to the 2014 National Drug Treatment Monitoring System, 64% of clients in alcohol services were male and the median age was 43 years (Public Health England, 2014a). The ethnic mix of the current sample is slightly more diverse compared to the national figures (79 vs. 92% white), reflecting the greater ethnic diversity of London. The majority of participants were unemployed, suggesting the severity of their dependence on alcohol. Those participants that were employed were split evenly between service and manual occupations (e.g. carpenter, shop assistant) and managerial and professional occupations (e.g. advertising executive, administrator).

Table 3.2: Demographic characteristics of sample at baseline (n=62)

|                   |   |
|-------------------|---|
| Mean age          | 43.4 years (range = 25-65 years; SD = 9.6, median = 44)                                 |
| Gender            | 39 (62.9%) male<br>23 (37.1%) female  |
| Ethnic group      | 49 (79%) white<br>7 (11.3%) black<br>4 (6.5%) Asian<br>1 (1.6%) mixed<br>1 (1.6%) other |
| Employment status | 45 (72.6%) unemployed in last year<br>17 (27.4%) employed in last year                  |

Participants' family circumstances are detailed in Table 3.3 below. While a large majority of those in the study had children (nearly 86%), only 37% were in intact relationships. Thirty-two percent were single, and the final third of the sample were estranged from their partners. Participants' relationships, whether estranged or intact, were of long standing – 12.6 years duration on average. The sample's 62 participants were parents to a total of 125 children. Though more than half of these were 18 years of age or under (56.8%), only around 20% of participants were actually sharing a home with their children. Given that hardly any of these children were in care, one can assume that the responsibility for parenting is falling on partners, ex-partners, or other family members.

Table 3.3: Family situations of sample at baseline (n=62)

|  |  |
|--|--|
| Relationship status                            | 17 (27.4%) in a relationship<br>16 (25.8%) single<br>15 (24.2%) in a relationship but separated<br>6 (9.7%) married<br>4 (6.5%) married but separated<br>4 (6.5%) divorced |
| Mean length of current relationship (n=42)     | 12.6 years (range = .02-37 years; SD = 11)   |
| Have children                                  | 53 (85.5%) yes<br>9 (14.5%) no   |
| Mean number of children per participant (n=53) | 2 (range = 0-5; SD = 1.4)  |

|  |  |
|--|--|
| Number of affected children                        | 20 Aged 6 and under<br>26 Aged 7-12<br>25 Aged 13-18<br>54 Aged 19+  |
| Have a child in care (n=53)                        | 48 (90.6%) No<br>5 (9.4%) Yes  |
| Living arrangements before treatment entry (n=62)* | 20 (32.3%) Alone<br>12 (19.4%) With children<br>16 (25.8%) With partner<br>15 (24.2%) With parent(s)<br>10 (16.1%) With housemate(s)<br>1 (1.6%) With other family member(s) |

\*Categories not mutually exclusive except “Alone”

Table 3.4 below describes the substance use of the sample. Inclusion criteria required that participants specify alcohol as the primary substance for which they were seeking treatment. Even so, just over half of the sample (56.5%) reported using other drugs in the 30 days before detoxification. The most frequently used drugs were those with a depressant effect, including cannabis (24.2%), the opiates heroin and codeine (21%) and the benzodiazepines chlordiazepoxide (Librium) and diazepam (Valium) (9.7%). Stimulant use was reported by 16 participants (26%); this included powder cocaine, crack cocaine, speed and methamphetamine. One service user had taken a hallucinogen (LSD).

According to the NICE alcohol guidelines (NICE, 2011), a score of 31 or more on the SADQ indicates severe alcohol dependence – the mean score for the study sample was 36.6. The majority of the sample (71%) would be categorised as severely dependent on alcohol according to the NICE guidance, with around a quarter of participants qualifying as moderately dependent. Participants were consuming on average 35.4 units per day, well above the recommended 2-3 units for women and 3-4 units for men, with the top 10% of the sample consuming on average 76 units/day. The pattern of consumption was overwhelmingly regular, with 61% of the sample not having had a single day abstinent in the month before admission; the mean number of days abstinent in the previous 30 days

was 1.5. Binge drinking patterns, characterised by periods of consumption alternating with periods of abstinence, did not appear in this sample.

On average, participants positively endorsed 67% of the alcohol-related problems listed on the APQ Common scale at intake, indicating significant disruption to their daily lives due to their alcohol consumption. The most frequently endorsed items were increased time spent drinking alone (91.9%), anhedonia (85.5%), and physical neglect (83.9%).

Table 3.4: Substance use of sample at baseline (n=62)

|  |   |
|--|---|
| Substance use  | 27 (43.5%) Alcohol only<br>35 (56.5%) Polydrug use  |
| Other reported drug use in the month before treatment* | 15 (24.2%) Cannabis<br>13 (21%) Cocaine or crack<br>12 (19.4%) Heroin<br>6 (9.7%) Benzodiazepines<br>4 (6.5%) Methamphetamine<br>1 (1.6%) Codeine<br>1 (1.6%) Speed<br>1 (1.6%) LSD |
| Mean units of alcohol per drinking day                 | 35.4 (range = 8.2-84.4, SD = 19.3)  |
| Mean days abstinent                                    | 1.5 (range = 0-10; SD = 2.6)  |
| Mean SADQ score  | 36.6 (range = 13-58; SD = 11.5)   |
| Severity of dependence based on SADQ scores            | 3 (4.8%) Mild dependence<br>15 (24.2%) Moderate dependence<br>44 (71%) Severe dependence  |
| Mean number of APQ Common items endorsed               | 15.4 out of 23 (range = 7-23; SD = 3.9)   |

\*Categories are not mutually exclusive

Table 3.5 below summarises several measures used to describe the family's relationships to the alcohol patient and to substance use at the point of treatment entry. The APQ Marital scale, administered to all participants in current relationships (estranged or intact, n=42), asks respondents about the presence of common alcohol-related relationships problems; on average, patients reported experiencing just over half of these problems. The most frequently endorsed items were partners complaining about drinking



(95.1%), shouting at partners while intoxicated (75.6%), and partners attempting to stop patients from drinking (73.2%).

Partners themselves tended to drink, and 39% were described by participants as heavy or moderate drinkers. A sizeable minority were teetotal (26.8%), with a subset of these (10%) pursuing their own recovery. Partners reacted negatively to patients' drinking on the whole - 61% either did not approve or made them leave. Patients perceived a large percentage of their partners, however, as having accepted their drinking (24.4%) or at least as being neutral to it (9.8%). One participant felt her partner encouraged her drinking. Nevertheless, 75.6% of participants said their partners supported or strongly supported their decision to seek treatment. The remainder of the sample were unsure how their partners felt (9.8%), or guessed they had neutral (4.9%) or mixed feelings (12.2%). Only half of those who reported acceptance of their drinking or less than clear support for treatment had partners who were heavy or moderate drinkers themselves. These figures speak to the range of ways families react to alcohol use, and highlight that even at point of treatment, support for abstinence is not always universal.

The APQ Children scale, which asks about the presence of common alcohol-related parent-child problems, was administered to all participants who were parents (n=53). On average, patients reported experiencing about half of the problems listed. The most frequently endorsed items were children criticising drinking (62.7%) and children avoiding patients when intoxicated (56.9%). A note of caution is necessary here: given that the experiences described in the APQ Children require parent-child interaction, and many parents in the sample did not live with their children or drink around them, these figures may describe an absence of alcohol-related conflict with children that is more an artefact of the measure than a reflection of the reality of these relationships.

Table 3.5: Substance use and participants' relationships with partners and children (n=41)

|   |   |
|---|---|
| Partner's alcohol or drug use status (IPI, n=41)*   | 4 (9.8%) Heavy drinker or user<br>12 (29.3%) Moderate drinker or user<br>13 (31.7%) Light drinker or user<br>7 (17.1%) Abstainer<br>4 (9.8%) Recovering alcoholic or drug user<br>1 (2.4%) Don't know |
| Partner's reaction to drinking (IPI, n=41)*         | 1 (2.4%) Encouraged<br>10 (24.4%) Accepted<br>4 (9.8%) Neutral<br>15 (36.6%) Did not accept<br>10 (24.4%) Left or made you leave<br>1 (2.4%) Don't know   |
| Partner's reaction to treatment (IPI, n=41)*        | 23 (56.1%) Strongly supports it<br>8 (19.5%) Supports it<br>2 (4.9%) Neutral<br>5 (12.2%) Mixed<br>4 (9.8%) Don't know  |
| Mean number of APQ Marital items endorsed (n=41)*   | 4.9 out of 9 (range = 1-9; SD = 2.0)  |
| Mean number of APQ Children items endorsed (n=51)** | 2.2 out of 4 (range = 0-4; SD = 1.8)  |

\*1 participant failed to complete measure

\*\*1 participant failed to complete measure, 1 did not feel able to answer due to long-term estrangement from children

A summary of the treatment experiences of the current sample is shown in Table 3.6 below. As Public Health England uses treatment completion rates to make its commissioning decisions (Public Health England, 2014b), the current study defines outcomes on this basis. Participants were funded for an average of 13.5 days of detoxification followed by 13.9 weeks of residential rehabilitation, and just over half of the sample completed their treatment programmes (51.6%). Those who dropped out did so after an average of about 8 weeks, while those who completed were in treatment for an average of 17.4 weeks. Of the latter group, only 3 of the 32 patients were initially funded for more than the standard 12 week rehabilitation programme – 15 others successfully applied for additional funding during treatment. Ultimately drop-outs only completed

around half of their funded programmes on average, while successful patients stayed longer than they originally intended by an average of 35.7%.

Attempts to collect longer-term treatment outcomes were more successful among treatment completers, of whom only 21.9% were lost to follow-up at one month post-discharge. The majority were maintaining abstinence (71.9%), though 6 participants had lapsed briefly before resuming recovery. Two participants had relapsed completely and returned to drinking, and at least some of those lost to follow-up are likely to have relapsed as well. Amongst treatment drop-outs, the majority were unable to be contacted either directly or through their locators (53.3%). Treatment terminations were overwhelmingly due to relapse or treatment abandonment, so these participants can be assumed to have resumed alcohol use. A further 40% percent were confirmed relapses. Two service users had left their rehabilitation programmes early but were maintaining abstinence.

Table 3.6: Treatment characteristics of sample (n=62)

|   |  |
|---|--|
| Recruitment site  | 34 (54.8%) Detoxification Centre C<br>27 (43.5%) Detoxification Centre D<br>1 (1.6%) Detoxification Centre A                                       |
| Average length of detoxification                          | 13.5 days (range = 7-28 days; SD = 4.6)  |
| Average length of initial funding                         | 13.9 weeks (range = 12-24 weeks; SD = 4.3)   |
| Treatment completion                                      | 32 (51.6%) yes<br>30 (48.4%) no  |
| Average length of treatment programme – drop-outs (n=30)  | 8.3 weeks (range = .14-22 weeks, SD = 6)   |
| Average length of treatment programme – completers (n=32) | 17.4 weeks (range = 8-24 weeks, SD = 5.5)  |
| Average % completed – drop-outs (n=30)                    | 55% (range = 1.2%-183.3%*, SD = 44%)   |
| Average % completed – completers (n=32)                   | 135.7% (range =66.77%** -200%, SD = 36.2%)   |
| Post-discharge follow-up – drop-outs (n=30)               | 16 (53.3%) lost to follow-up<br>12 (40%) relapsed to alcohol use<br>1 (3.3%) lapsed, but returned to abstinence<br>1 (3.3%) maintaining abstinence |

|  |  |
|--|--|
| Post-discharge follow-up – completers (n=32) | 17 (53.1%) maintaining abstinence<br>7 (21.9%) lost to follow-up<br>6 (18.8%) lapsed, but returned to abstinence<br>2 (6.3%) relapsed to alcohol use |
|--|--|

\* Drop-outs who completed over 100% of their initially funded stay still terminated unexpectedly before completing their additionally funded treatment

\*\* Completers who completed less than 100% of their funded stay had decided at treatment intake to pursue a shorter programme and their endings were planned

### Data analysis: Individual and family functioning at baseline

The following section describes the study sample at baseline, when questionnaires were administered to participants at intake for detoxification. The study's primary and secondary hypotheses – (1) that healthier family functioning at intake will be associated with and predictive of treatment outcome and (2) that family relationships will change across the rehabilitation process – were tested based upon the cohesion, flexibility, communication, conflict and satisfaction patients reported in their families at this point. This section also summarises participant data on two key individual predictors of relapse at baseline, alcohol consumption/dependency and psychological symptomology, which, when controlled for, allow us to better determine the independent effects of family functioning. Finally, an exploratory analysis of the potential moderating effects of baseline attachment anxiety and avoidance is described.

All data analysis for the current project was undertaken in SPSS Version 22.0 (2013). Questionnaires were double entered and cross-checked for errors before analysis began. As there is no control group in a cohort study, normative data has been used in the sections below to help contextualise the baseline responses of the study sample. These comparisons should be interpreted with care – though the normative samples aim to be representative of the general population, they were largely collected outside of the UK.

*Alcohol consumption and dependency.* Patients' self-report data from their Timeline Follow-back interviews at intake were used to calculate the number of alcohol

units each had consumed in the 30 days prior to detoxification. Units were calculated on a per drink basis by multiplying the percent alcohol by volume (ABV) of the drink by the number of millilitres consumed, and then dividing this figure by 1,000. Daily and monthly unit totals were then summed. On the whole, participants' consumption was so strictly routinised that identifying the specific brands and volumes consumed was not problematic. In the case of lager, the volume of the can varies depending on where the drink is purchased (e.g. off-licence can sizes are larger than supermarket sizes), so this information was requested where applicable to allow the unit calculation to be more precise. Glass, shot and bottle sizes were standardised according to Table 3.7 below, derived from the NHS Drinks and Units guide (NHS, 2015).

Table 3.7: Standardised alcohol measures used in the current study

|                           |       |
|---------------------------|-------|
| Single shot               | 25ml  |
| Double shot               | 50ml  |
| Standard glass of wine    | 175ml |
| Large glass of wine       | 250ml |
| Quarter bottle of spirits | 175ml |
| Half bottle of spirits    | 350ml |
| Bottle of spirits         | 700ml |
| Bottle of wine            | 750ml |
| Pub pint measure          | 568ml |

In cases where participants could not remember the brand of alcohol consumed, standardised ABVs were used (see Table 3.8), again derived from the NHS Drinks and Units guide (NHS, 2015). Only spirits and wine required standardised ABVs, as participants consistently remembered their lager or cider of choice. In the case of wine, 15 participants were able to identify an approximate ABV but not a brand; as participants tended to know very well the strength and quantity of drink necessary to avoid withdrawal symptoms, these ABVs were used in the calculations. The standardised 12% ABV was

only used in 4 cases; this is a conservative ABV which may underestimate consumption for these participants.

Table 3.8: Standardised alcohol by volume (ABV) levels used in the current study

|  |     |
|--|-----|
| Spirits (brandy, gin, rum, sambuca, tequila, vodka)* | 40% |
| Wine   | 12% |

\*The six spirits listed are those where at least one participant could not identify a brand; they are not the only spirits consumed by participants

Once monthly alcohol units were calculated, they were combined with participants' reported number of days abstinent to derive key consumption variables – drinks per drinking day (DDD) and percent days abstinent (PDA). Summary figures for the whole sample at baseline are shown in Table 3.9 below. There were significant gender differences in both total consumption,  $t(60) = 2.59$ ,  $p = .012$ , and drinks per drinking day,  $t(60) = 2.42$ ,  $p = .019$  (see Table 3.10), but there was no difference between men and women in the pattern of consumption (operationalised as PDA) or in the level of dependency based on SADQ scores. Polydrug users and alcohol users did not differ significantly on any of the alcohol-related variables, nor did participants differ by age or study site.

Table 3.9: Alcohol consumption in units in the 30 days prior to detoxification (n=62)

|  |   |
|--|---|
| Mean total units of alcohol                  | 1004.5 (range = 275.4-2365.8; SD = 537.3) |
| Mean units of alcohol per drinking day (DDD) | 35.4 (range = 8.2-84.4, SD = 19.3)        |
| Mean days abstinent                          | 1.5 (range = 0-10; SD = 2.6)              |
| Mean percent days abstinent (PDA)            | 5.0 (range = 0-33; SD = 8.6)              |

Table 3.10: Significant gender differences in alcohol consumption

| Variable                | Men <sup>1</sup><br>(n=39) | Women <sup>2</sup><br>(n=23) | Mean<br>difference <sup>1-2</sup> | Sig.<br>(2-tailed) |
|-------------------------|----------------------------|------------------------------|-----------------------------------|--------------------|
| Monthly alcohol units   | M = 1134.2;<br>SD = 532.6  | M = 784.7;<br>SD = 479.7     | 349.6                             | .012               |
| Drinks per drinking day | M = 39.8;<br>SD = 19.2     | M = 28.0;<br>SD = 17.5       | 11.8                              | .019               |

*Individual psychological functioning.* The HSCL-25, administered to control for psychological symptoms known to predict relapse, contained both anxiety and depression subscales. Summary statistics for the sample at baseline are shown in Table 3.11; scores were calculated by averaging the ratings participants gave (on a 1-4 scale) to describe the frequency with which they experienced a range of psychological symptoms. Scores above 1.75 are predictive of psychological distress on clinical interview (Hesbacher et al., 1980); in a normative population, only 11% exceeded this threshold (Strand, Dalgard, Tambs, & Rognerud, 2003). Average scores in the current sample notably surpass the 1.75 level, suggesting high levels of emotional symptomology.

No significant differences were found in total, anxiety or depression scale scores based on gender, polydrug use, or study site. There was, however, a significant difference in anxiety between those above ( $M = 2.5$ ,  $SD = .79$ ) and those below ( $M = 3.0$ ,  $SD = .74$ ) the mean age for the sample,  $t(60) = -2.3$ ,  $p = .025$ , with younger participants reporting more anxiety.

Table 3.11: Individual psychological functioning based on the HSCL-25

|  |                                  |
|--|----------------------------------|
| Mean HSCL-25 Total Symptomology score  | 2.9 (range = 1.2-4; $SD = .69$ ) |
| Mean HSCL-25 Anxiety subscale score    | 2.7 (range = 1.1-4; $SD = .79$ ) |
| Mean HSCL-25 Depression subscale score | 3.0 (range = 1.3-4; $SD = .69$ ) |

*Family functioning.* In order to exhaustively operationalise family functioning during the transition to rehabilitation, several key dimensions of family process were measured: family cohesion, flexibility, communication, conflict and satisfaction. Though these variables correlate significantly with one another in the expected directions (see Table 3.12), the strength of the correlations is largely moderate, and the variables theoretically describe different processes. The strongest relationship was a positive correlation between patients' ratings of their family communication and their satisfaction

with family life,  $r(60) = .735$ ,  $p < .001$ . This finding may speak to the value patients place on this aspect of family functioning, but could also result from the similarity of the measures used: both the Family Communication Scale and the Family Satisfaction Scale ask the respondent to rate the *quality* of family life rather than to report the presence or absence of specific family processes.

Table 3.12: Correlations between family variables

|               | Cohesion | Flexibility | Communication | Conflict | Satisfaction |
|---------------|----------|-------------|---------------|----------|--------------|
| Cohesion      | 1        | .658**      | .686**        | -.373**  | .605**       |
| Flexibility   | .658**   | 1           | .547**        | -.360**  | .536**       |
| Communication | .686**   | .547**      | 1             | -.429**  | .735**       |
| Conflict      | -.373**  | -.360**     | -.429**       | 1        | -.383**      |
| Satisfaction  | .605**   | .536**      | .735**        | -.383**  | 1            |

\*\* $p < .002$ , one-tailed

Cohesion and flexibility, two of the key organising dimensions of systemic functioning, were derived from the FACES-IV instrument. These variables attempt to capture how well the family manages distance and responds to change respectively, both processes implicated in the transition to residential rehabilitation and crucial to family reorganisation during the shift to sobriety in general. The variables are operationalised as ratios of balanced to unbalanced functioning for each construct according to the following formulas (Olson, 2010):

$$\text{Cohesion Ratio} = \text{Balanced Cohesion score} / \frac{(\text{Disengaged score} + \text{Enmeshment score})}{2}$$

$$\text{Flexibility Ratio} = \text{Balanced Flexibility score} / \frac{(\text{Rigid score} + \text{Chaotic score})}{2}$$

Thus, the cohesion ratio looks at how strongly the extremes of cohesion (disengagement and enmeshment) are perceived by the patient compared to the level of healthy cohesion, while the flexibility ratio compares the perception of rigid and chaotic behaviour with the recognition of more balanced flexibility in the system. Ratio scores



below 1 indicate the predominance of the less functional extremes of flexibility and cohesion, while scores above 1 imply healthier patterns.

Summary cohesion and flexibility ratios are shown in Table 3.13 below. Though there was variability in the way alcohol patients perceived their families on these two dimensions, on average they rated their functioning at intake as healthy: mean ratio scores were above 1 for both variables, indicating the prevalence of functional over extreme behaviour. The mean cohesion ratio in particular was firmly in the balanced range, with nearly two and a half times as much balanced cohesion reported as disengagement or enmeshment.

Mean percentile scores for the individual subscales used in the ratio calculations are shown in Table 3.14. Raw scores on these subscales were converted to percentiles as per the scoring instructions and accompanying conversion tables in the FACES-IV manual (Olson, 2010), where descriptive ratings for each percentile score were also provided. On average, the sample scores at the low end of each of the extreme subscales (disengagement, enmeshment, rigidity and chaos), even in comparison with the normative population, while remaining decisively midrange in terms of balanced cohesion and flexibility. These subscale scores help to contextualise the ratio scores: while there appears to be more balance than imbalance in patients' family systems at intake, this does not signify that their levels of flexibility and connectedness are correspondingly high. In fact, the sample's flexibility and cohesion levels are both very close to the normative mean, i.e. the 50<sup>th</sup> percentile.

Table 3.13: Mean cohesion and flexibility ratios at baseline

|                        |                                |
|------------------------|--------------------------------|
| Mean cohesion ratio    | 2.4 (range = .4-6.1; SD = 1.6) |
| Mean flexibility ratio | 1.5 (range = .3-4.2; SD = .9)  |

Table 3.14: Cohesion and flexibility subscales for the sample at baseline

|                                 | <b>Mean cohesion scores</b>     | <b>Descriptive rating</b> |
|---------------------------------|---------------------------------|---------------------------|
| Balanced cohesion percentile    | 61.0 (range = 20-85; SD = 20.2) | Connected                 |
| Disengagement percentile        | 41.3 (range = 12-95; SD = 22.3) | Low                       |
| Enmeshment percentile           | 26.6 (range = 12-68; SD = 13.2) | Very low                  |
|                                 | <b>Mean flexibility scores</b>  | <b>Descriptive rating</b> |
| Balanced flexibility percentile | 51.1 (range = 22-85; SD = 17.8) | Flexible                  |
| Rigid percentile                | 43.6 (range = 13-98; SD = 21.9) | Moderate                  |
| Chaotic percentile              | 37.0 (range = 10-85; SD = 20.5) | Low                       |

Three other variables measuring discrete aspects of family functioning were collected and mean values for the sample are shown in Table 3.15. The level of overt conflict in participants' families was assessed using the conflict subscale of the FES. On average participants positively endorsed just under half of the conflict scenarios, the most frequently reported being family members losing their tempers (74.2%) and criticising each other (67.7%). Physical violence – described as “sometimes hitting each other” – was the least endorsed item but was still reported by a sizeable percentage of participants (24.2%). Comparison with data from normative ( $M = 3.2$ ,  $SD = 1.9$ ) and distressed ( $M = 4.0$ ,  $SD = 2.1$ ) samples show that the current sample does not differ significantly from the latter group,  $t(61) = .654$ ,  $p = .516$ .

The Family Communication and Family Satisfaction Scales are secondary measures associated with the FACES-IV package, both of which ask the respondent to comment on the perceived quality of family life. As with the FACES-IV measure, raw scores are assigned percentile rankings based on normative data; the mean percentiles for the sample and associated descriptive ratings can be seen in Table 3.15. On average, alcohol patients in the current study reported being moderately happy with their family's communication, a rating more or less the same as that given by the normative population, where the 50<sup>th</sup> percentile represents the mean score. The sample was less satisfied overall

with their family relationships, however: they rated their family satisfaction as low and were in the bottom third of respondents when compared with the normative dataset.

Table 3.15: Mean family functioning scores at baseline

|                               |                                 |          |
|-------------------------------|---------------------------------|----------|
| Mean conflict score           | 4.2 (range = 0-9; SD = 2.3)     |          |
| Mean communication percentile | 52.1 (range = 10-99; SD = 29.8) | Moderate |
| Mean satisfaction percentile  | 31.8 (range = 10-99; SD = 30.1) | Low      |

In summary, in terms of family functioning, the current sample of alcohol patients only differs on average from normative comparison groups in the level of overt conflict present (more) and in participants' self-reported satisfaction with family life (less). The correlation between these two variables is significant,  $r(60) = -.383$ ,  $p = .001$ , but weak. No differences were found in any of the family functioning variables in terms of age or gender.

Interestingly, several significant differences were found between polydrug users and those consuming only alcohol (see Table 3.16). Polydrug users rank significantly lower in terms of their balanced cohesion and flexibility subscale scores, their cohesion ratios, and their communication and satisfaction scores. This difference means that unlike the sample as a whole, polydrug users have flexibility and communication scores that fall below the normative mean (below the 50<sup>th</sup> percentile). They also have significantly higher enmeshment scores than alcohol users, though these are still very low relative to the average (30<sup>th</sup> percentile). Satisfaction percentiles for both groups remain below the mean of the normative comparison group, but the large mean difference between alcohol and polydrug users (23.91 percentage points) indicates that the latter group is significantly more dissatisfied with family life, dragging down the collective average for the sample.

Table 3.16: Significant differences in family functioning by polydrug use status

| <b>Variable</b>                 | <b>Polydrug users<sup>1</sup></b><br>(n=35) | <b>Alcohol only<sup>2</sup></b><br>(n=27) | <b>Mean difference</b><br>1-2 | <b><i>t</i></b> | <b><i>df</i>*</b> | <b><i>p</i></b><br>(2-tailed) |
|---------------------------------|---|---|-------------------------------|-----------------|-------------------|-------------------------------|
| Balanced cohesion percentile    | M = 55.89;<br>SD = 17.56                    | M = 67.52;<br>SD = 21.78                  | -11.63                        | -2.329          | 60                | .023                          |
| Balanced flexibility percentile | M = 47.11;<br>SD = 16.19                    | M = 56.33;<br>SD = 18.80                  | -9.22                         | -2.072          | 60                | .043                          |
| Enmeshment percentile           | M = 29.71;<br>SD = 14.86                    | M = 22.52;<br>SD = 9.56                   | 7.2                           | 2.312           | 58.3              | .024                          |
| Cohesion ratio                  | M = 1.97;<br>SD = 1.50                      | M = 2.92;<br>SD = 1.64                    | -.95                          | -2.375          | 60                | .021                          |
| Communication percentile        | M = 43.91;<br>SD = 26.86                    | M = 62.63;<br>SD = 30.51                  | -18.72                        | -2.564          | 60                | .013                          |
| Satisfaction percentile         | M = 21.43;<br>SD = 22.11                    | M = 45.33;<br>SD = 33.98                  | -23.91                        | -3.174          | 42.3              | .003                          |

\*Degrees of freedom below 60 indicate that equality of variance could not be assumed based on Levene's test

There were also significant differences in balanced cohesion, communication and satisfaction scores between the study sites, with all three lower at Detoxification Centre C than at Detoxification Centre D (see Table 3.17). This is likely due to the greater concentration (64.7 vs 48.1%) and severity of polydrug users at Detoxification Centre C, which, unlike Detoxification Centre D, admits both alcohol and drug users.

Table 3.17: Significant differences in family functioning by study site

| <b>Variable</b>              | <b>Centre C<sup>1</sup></b><br>(n=34) | <b>Centre D<sup>2</sup></b><br>(n=27) | <b>Mean difference</b><br>1-2 | <b><i>t</i></b> | <b><i>df</i>*</b> | <b><i>p</i></b><br>(2-tailed) |
|------------------------------|---------------------------------------|---------------------------------------|-------------------------------|-----------------|-------------------|-------------------------------|
| Balanced cohesion percentile | M = 55.91;<br>SD = 20.44              | M = 67.26;<br>SD = 18.76              | -11.35                        | -2.232          | 59                | .029                          |
| Communication percentile     | M = 43.74;<br>SD = 26.41              | M = 62.33;<br>SD = 31.50              | -18.60                        | -2.508          | 59                | .015                          |
| Satisfaction percentile      | M = 24.24;<br>SD = 23.28              | M = 41.30;<br>SD = 35.67              | -17.06                        | -2.149          | 42.7              | .037                          |

\*Degrees of freedom below 59 indicate that equality of variance could not be assumed based on Levene's test

*Attachment anxiety and avoidance.* The ECR-R was administered to all participants in current relationships, estranged or intact (n=42). One participant declined to complete the measure, making the total sample for these exploratory analyses n=41. The ECR-R asks participants to rate the degree to which they agree or disagree (on a 1-7 scale) with 36 scenarios describing their current relationship. Half of the scenarios assess participants' anxiety about the availability of their romantic partner; the other half consider the degree to which participants avoid intimacy. Summary statistics for this subsample are found in Table 3.18 below. Comparisons with normative data provided by the instrument's author indicate that the current sample is no more anxious than a control group (M = 3.56, SD = 1.12) but is significantly more avoidant on average (M = 2.92, SD = 1.19),  $t(40) = 2.76$ ,  $p = .009$  (Fraley, 2012). No significant differences were found in terms of attachment anxiety or avoidance by age, gender, polydrug use or study site.

Table 3.18: Summary statistics, attachment anxiety and avoidance (n=41)

|                                 |                                     |
|---------------------------------|-------------------------------------|
| Mean attachment anxiety score   | 3.57 (range = 1.17-6.33; SD = 1.22) |
| Mean attachment avoidance score | 3.55 (range = 1.17-6.44; SD = 1.47) |

In order to evaluate the utility of considering attachment variables as moderators of outcome, an exploratory analysis was undertaken to identify differences in family functioning between groups high and low on attachment anxiety and avoidance. Groups were created by dividing the sample at the mean value: participants scoring above the sample mean were considered high on attachment anxiety and avoidance, while participants scoring at or below this mean were considered low. No significant differences between those high and low on attachment anxiety were found for any of the family variables. Significant differences between high and low attachment avoidance groups are shown in Table 3.19 below. The high attachment avoidance group evidenced significantly

poorer family functioning across eight measures, dropping below the normative mean (i.e. the 50th percentile) on flexibility and communication. They reported significantly more disengaged and chaotic behaviour – the extreme ends of cohesion and flexibility characterised by distance taking – than less avoidant participants, but still remained below the normative mean values for both. Their mean satisfaction percentile was the lowest of any group calculated thus far.

Given that the current sample of alcohol inpatients scores significantly higher than a normative sample on attachment avoidance, and that those with the highest levels of avoidance within this group are reporting significantly poorer family functioning, this variable will be considered as a potential moderator of outcome in the next section. Due to the smaller sample size completing the ECR-R (n=41), this analysis will be exploratory.

Table 3.19: Significant differences in family functioning by attachment avoidance level

| <b>Variable</b>                 | <b>High<sup>1</sup><br/>(n=18)</b> | <b>Low<sup>2</sup><br/>(n=23)</b> | <b>Mean<br/>difference<sup>1-2</sup></b> | <b><i>t</i></b> | <b><i>df</i></b> | <b><i>p</i><br/>(2-tailed)</b> |
|---------------------------------|------------------------------------|-----------------------------------|--|-----------------|------------------|--------------------------------|
| Balanced cohesion percentile    | M = 55.17;<br>SD = 20.83           | M = 69.43;<br>SD = 14.15          | -14.27                                   | -2.608          | 39               | .013                           |
| Balanced flexibility percentile | M = 43.33;<br>SD = 18.47           | M = 56.83;<br>SD = 14.60          | -13.49                                   | -2.614          | 39               | .013                           |
| Disengagement percentile        | M = 44.39;<br>SD = 20.46           | M = 31.30;<br>SD = 17.41          | 13.09                                    | 2.212           | 39               | .033                           |
| Chaotic percentile              | M = 41.00;<br>SD = 14.97           | M = 26.00;<br>SD = 16.85          | 15                                       | 2.968           | 39               | .005                           |
| Cohesion ratio                  | M = 2.04;<br>SD = 1.39             | M = 3.23;<br>SD = 1.69            | -1.19                                    | -2.405          | 39               | .021                           |
| Flexibility ratio               | M = 1.18;<br>SD = .60              | M = 1.88;<br>SD = 1.03            | -.70                                     | -2.572          | 39               | .014                           |
| Communication percentile        | M = 41.89;<br>SD = 26.11           | M = 59.96;<br>SD = 26.59          | -18.07                                   | -2.176          | 39               | .036                           |
| Satisfaction percentile         | M = 17.00;<br>SD = 15.29           | M = 43.22;<br>SD = 34.22          | -26.22                                   | -3.017          | 39               | .004                           |

## Data analysis: Baseline predictors of outcome

To identify significant relationships between baseline family functioning variables and treatment completion, a series of two-tailed independent samples t-tests were run. The results of these t-tests are shown in Table 3.20. Only one family variable – family satisfaction – was related to outcome, and the relationship was not in the expected direction: treatment drop-outs reported being significantly more satisfied with their family lives at intake than treatment completers,  $t(48.03) = 2.44$ ,  $p = .018$ . Though there were no other significant differences between the two groups, all but one of the mean differences were in the opposite of the hypothesised direction – treatment drop-outs reported healthier family functioning on every measure except the rigidity subscale.

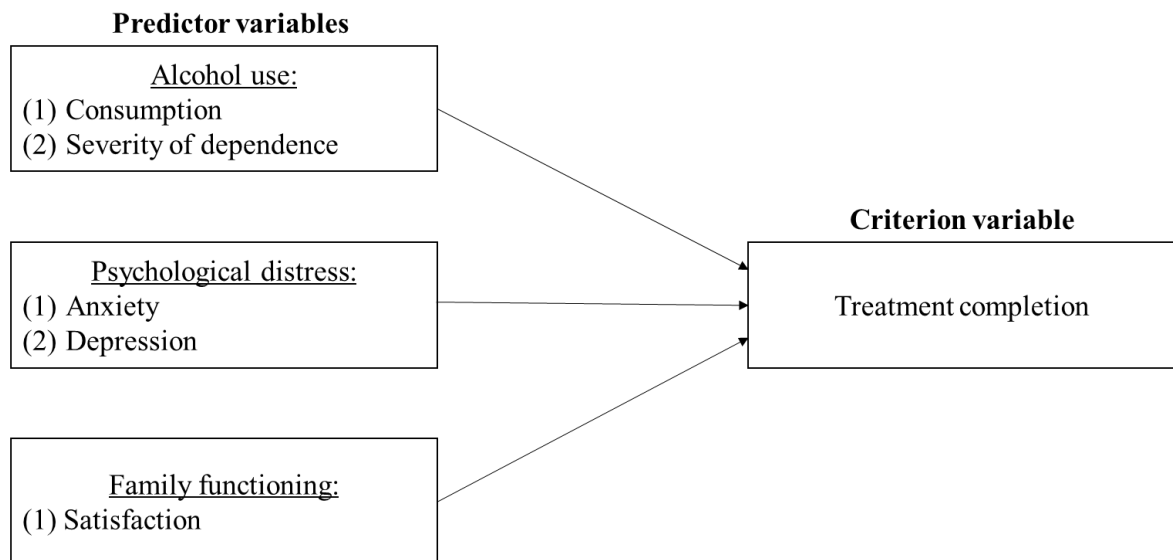
Table 3.20: Differences in family functioning between treatment completers and drop-outs

| Variable                 | Drop-outs <sup>1</sup><br>(n=30) | Completers <sup>2</sup><br>(n=32) | Mean<br>difference <sup>1-2</sup> | <i>t</i> | <i>df</i> * | <i>p</i><br>(2-tailed) |
|--------------------------|----------------------------------|-----------------------------------|-----------------------------------|----------|-------------|------------------------|
| Conflict score           | M= 4.17;<br>SD = 2.59            | M = 4.22;<br>SD = 2.11            | -.052                             | -.087    | 60          | .931                   |
| Cohesion percentile      | M = 63.43;<br>SD = 22.53         | M = 58.63;<br>SD = 17.79          | 4.81                              | .929     | 55.2        | .357                   |
| Flexibility percentile   | M = 55.17;<br>SD = 20.30         | M = 47.34;<br>SD = 14.48          | 7.82                              | 1.74     | 52.2        | .088                   |
| Disengagement percentile | M = 39.27;<br>SD = 24.47         | M = 43.22;<br>SD = 20.33          | -3.95                             | -.693    | 60          | .491                   |
| Enmeshment percentile    | M = 26.03;<br>SD = 12.53         | M = 27.09;<br>SD = 14.02          | -1.06                             | -.313    | 60          | .755                   |
| Rigid percentile         | M = 45.27;<br>SD = 25.36         | M = 42.09;<br>SD = 18.25          | 3.17                              | .562     | 52.4        | .576                   |
| Chaotic percentile       | M = 36.67;<br>SD = 22.09         | M = 37.22;<br>SD = 19.33          | -.552                             | -.105    | 60          | .917                   |
| Cohesion ratio           | M = 2.69;<br>SD = 1.79           | M = 2.09;<br>SD = 1.41            | .595                              | 1.46     | 60          | .149                   |
| Flexibility ratio        | M = 1.71;<br>SD = 1.11           | M = 1.32;<br>SD = .62             | .385                              | 1.67     | 44.8        | .102                   |
| Communication percentile | M = 56.13;<br>SD = 33.20         | M = 48.25;<br>SD = 26.11          | 7.88                              | 1.04     | 60          | .301                   |
| Satisfaction percentile  | M = 41.23;<br>SD = 34.97         | M = 23.03;<br>SD = 21.81          | 18.20                             | 2.44     | 48.0        | .018**                 |

\*Degrees of freedom below 60 indicate that equality of variance could not be assumed based on Levene's test

Family satisfaction was then entered into a logistic regression model alongside known covariates to determine if baseline satisfaction would predict treatment completion. As there were no significant differences in completion rates by gender, age, polydrug use, or study site, none of these were included in the model. Key individual predictors of outcome based on previous research were (1) alcohol consumption, operationalised as DDD, (2) severity of alcohol dependence as measured by SADQ scores and (3) psychological distress using the anxiety and depression subscales of the HSCL-25.

**Figure 3.2: Visual summary of predictor variables tested in logistic regression model**



The resulting model was significantly more predictive than constant only,  $\chi^2(5, n=62) = 26.215, p = .00$ . Nagelkerke's  $R^2$  indicates that the predictors tested accounted for 46% of the variance in treatment outcome, which the model predicted correctly in 80.6% of cases (87.6% for treatment completers and 73.3% for drop-outs). Only three of the five predictors contributed significantly to the strength of the model, however: alcohol consumption (DDD), anxiety, and family satisfaction (see Table 3.21). According to this model, every percentile increase in the family satisfaction score at baseline decreased the odds of completing treatment by 4%, regardless of the patient's alcohol consumption, level



of dependency and psychological distress. The narrow 95% confidence intervals associated with family satisfaction indicate that this effect is highly predictable in this sample.

Table 3.21: Predictors based on logistic regression, model one (n=62, EPV=6)

| Variable     | B      | SE   | Wald  | df | Sig.   | Exp(B) | 95% C.I. for Exp(B) |       |
|--------------|--------|------|-------|----|--------|--------|---------------------|-------|
|              |        |      |       |    |        |        | Upper               | Lower |
| DDD          | -.079  | .026 | 9.371 | 1  | .002** | .924   | .879                | .972  |
| SADQ         | .068   | .042 | 2.689 | 1  | .101   | 1.071  | .987                | 1.162 |
| Anxiety      | -1.552 | .777 | 3.983 | 1  | .046** | .212   | .046                | .973  |
| Depression   | -.157  | .830 | .036  | 1  | .850   | .855   | .168                | 4.345 |
| Satisfaction | -.041  | .015 | 6.898 | 1  | .009** | .960   | .931                | .990  |

As the model above includes five predictors, it has an EPV of 6 (30 outcome events/5 predictors). While some authors argue that this is an acceptable level of power (Vittinghoff & McCulloch, 2007), a more conservative rule of thumb is to require at least 10 EPV (Peduzzi et al., 1996). Re-running the model with only the three significant predictors ensures the model meets this criterion. The resulting model is still significantly different from constant only,  $\chi^2 = 23.401$  (3, n=62),  $p = .00$ , but explains slightly less variance (Nagelkerke's  $R^2 = .419$ ) and predicts fewer cases correctly (72.6%). All three variables are still significant predictors of outcome (see Table 3.22). Every percentile increase in family satisfaction at baseline now predicts a 3.5% decrease in the odds of completing treatment.

Table 3.22: Predictors based on logistic regression, model two (n=62, EPV=10)

| Variable     | B      | SE   | Wald  | df | Sig.   | Exp(B) | 95% C.I. for Exp(B) |       |
|--------------|--------|------|-------|----|--------|--------|---------------------|-------|
|              |        |      |       |    |        |        | Upper               | Lower |
| DDD          | -.055  | .019 | 8.175 | 1  | .004** | .946   | .911                | .983  |
| Anxiety      | -1.012 | .466 | 4.712 | 1  | .030** | .363   | .146                | .906  |
| Satisfaction | -.036  | .014 | 6.862 | 1  | .009** | .965   | .939                | .991  |

*Attachment avoidance as moderator.* Out of the smaller sample of participants currently in relationships that completed the ECR-R measure (n=41), 19 dropped out of treatment and 22 finished successfully. Reproducing the logistic regression model above with the addition of attachment avoidance and a satisfaction x avoidance interaction to test moderation reduced the EPV to 3.8 for this analysis, which is therefore exploratory. The resulting model differed significantly from a constant only model,  $\chi^2 = 17.939$  (5, n=41),  $p = .003$ , and accounted for 47.3% of variance using Nagelkerke's  $R^2$ . The results in Table 3.23 show that though the interaction between family satisfaction and attachment avoidance did not reach significance, avoidance itself was a significant predictor of outcome. Higher scores on the ECR-R attachment avoidance scale decreased the odds of treatment completion, but the width of the confidence interval indicates that the magnitude of this effect is highly uncertain.

Table 3.23: Attachment avoidance as moderator, logistic regression (n=41, EPV 3.8)

| Variable             | B     | SE   | Wald  | df | Sig.   | Exp(B) | 95% C.I. for Exp(B) |       |
|----------------------|-------|------|-------|----|--------|--------|---------------------|-------|
|                      |       |      |       |    |        |        | Upper               | Lower |
| DDD                  | -.066 | .029 | 5.323 | 1  | .021** | .936   | .885                | .990  |
| Satisfaction         | -.109 | .053 | 4.269 | 1  | .039** | .897   | .809                | .994  |
| Attachment Avoidance | -.908 | .463 | 3.843 | 1  | .050** | .403   | .163                | 1.000 |
| Interaction          | .024  | .016 | 2.193 | 1  | .139   | 1.025  | .992                | 1.058 |
| Anxiety              | -.816 | .578 | 1.993 | 1  | .158   | .442   | .142                | 1.373 |

#### Data analysis: Family change across treatment

The secondary hypothesis of the study was that family functioning would change across the treatment process, and one of the study's aims was to determine whether any such changes would be in a predictable direction. Of the total study sample (n=62), 32 patients successfully completed treatment and it is this subsample that will be used in this analysis. Of these participants, 19 (59.4%) returned measures at time two and 15 (46.9%)

at time three. Because they are based on a smaller sample of completers with a diminishing response rate, these analyses are exploratory in nature.

A series of linear mixed models were run in an attempt to predict change longitudinally in each of the family functioning variables. Time was entered as a fixed effect and subject as a random effect. Time was statistically significant as a main effect (i.e. change across treatment was detected) when completers' perceived disengagement from their families was entered as the dependent variable,  $F(2, 12.97) = 6.685, p = .01$ . Estimates of the fixed effects contributing to this main effect showed that it was driven by a statistically significant difference in disengagement between time two and time three: treatment completers rated their families as significantly more disengaged (by a magnitude of ten percentile points) at one-month follow-up compared to their final month of rehabilitation,  $t(13.57) = -3.105, p = .008$  (see Table 3.24).

A second model testing time as a main effect with rigidity as the dependent variable only approached significance,  $F(2, 19.70) = 3.163, p = .064$ , but nevertheless identified a significant difference in perceived rigidity from time one to time two,  $t(22.18) = -2.309, p = .031$  (see Table 3.24). Treatment completers reported a significant reduction in rigidity of around 7 percentile points between intake and discharge from rehabilitation.

Table 3.24: Linear mixed modelling: Significant effects of time on family functioning

| Parameter             | Estimate | Std. Error | df     | t      | Sig. | Lower bound | Upper bound |
|-----------------------|----------|------------|--------|--------|------|-------------|-------------|
| Disengagement (T2-T3) | -10.650  | 3.429      | 13.572 | -3.105 | .008 | -18.027     | -3.273      |
| Rigidity (T2-T1)      | -6.847   | 2.966      | 22.182 | -2.309 | .031 | -12.994     | -.699       |

These two models were the only ones to find significant main effects for time, and as such they identify two instances where the subsample of completers is changing on

average in the same direction. Graphical representations of the data, however, suggest that the ratings of individual participants are in fact changing across the three time points, but not necessarily in a consistent direction that would allow a global effect to be detected. For example, see Figure 3.3 below, which fits a quadratic curve to the three flexibility ratings given by each of the 14 participants who completed the questionnaire measures at all three time points. The patterns of change in this small sample vary widely, but never does the fit line appear flat (i.e. no change), suggesting that participants *are* perceiving and reporting fluctuations in flexibility across the rehabilitation process. The other family variables – cohesion, communication, conflict and satisfaction – present similarly when represented graphically.

Figure 3.3: Changes in flexibility percentile score across the rehabilitation process (n=14)

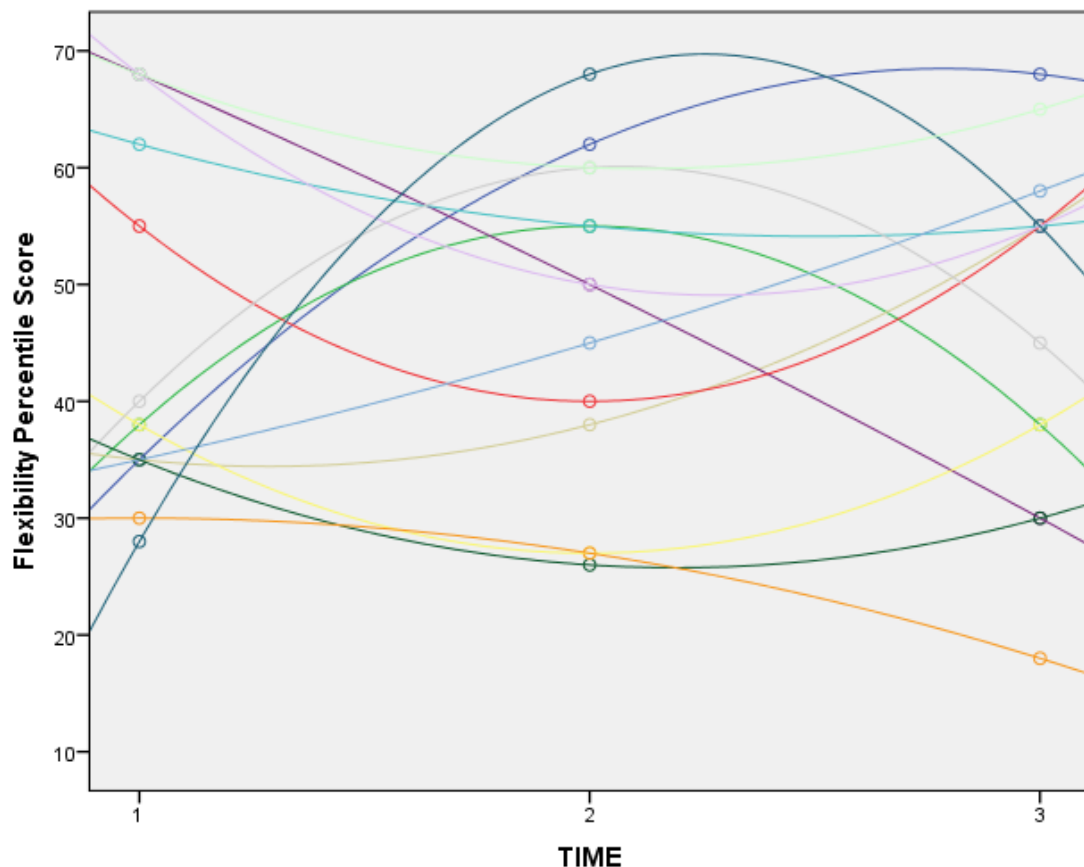
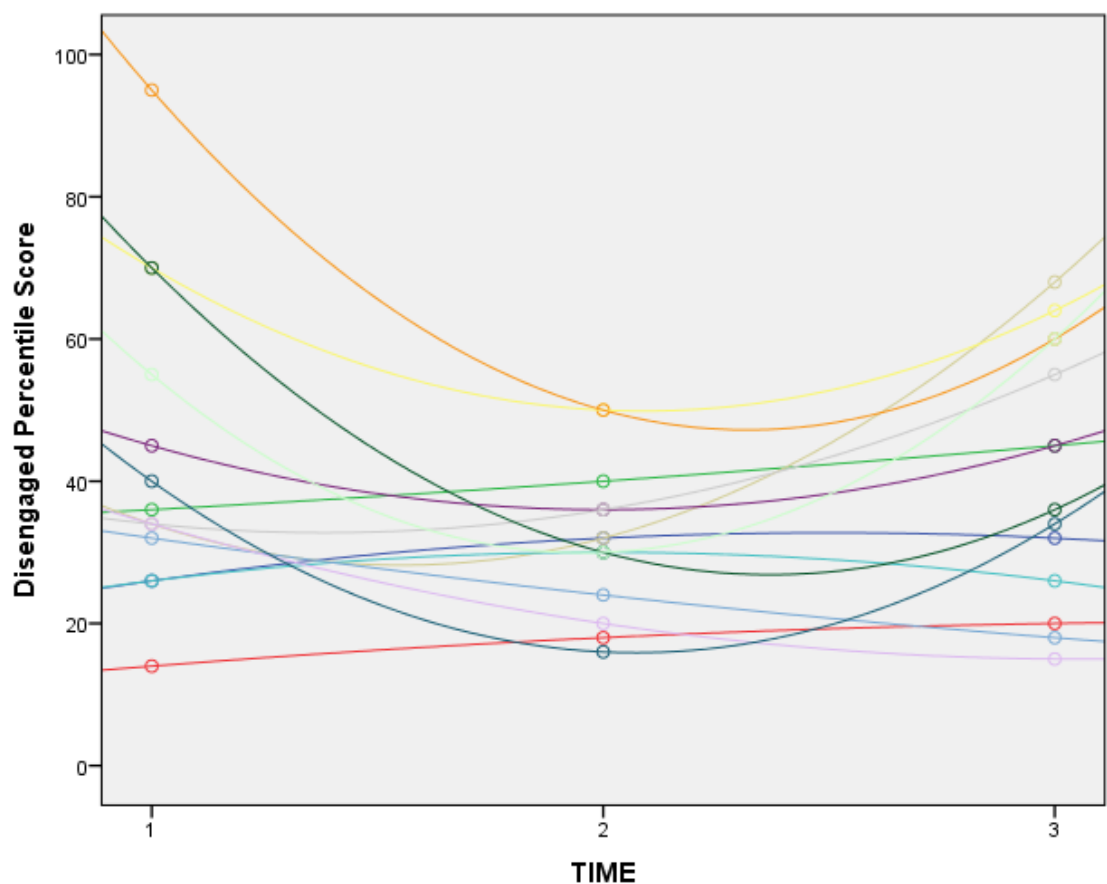


Figure 3.4 below visualises completers' ratings of disengagement in their families over the course of the study. Here one can see the effect detected in model one, of increasing disengagement across the sample from time two to time three – but what the model does not capture is that for some participants this change in disengagement seems to be the continuation of a gradual linear increase from baseline, while for others, it suggests a return to an earlier state of disengagement that was suspended during rehabilitation.

Figure 3.4: Changes in disengagement percentile across the rehabilitation process (n=14)



Thus while the global effects detected using linear mixed models were limited, perhaps this does not imply a lack of change across the rehabilitation process but rather that a variety of patterns of family change are possible. This finding would be consistent with the literature on family response to changes in alcohol use described in Chapter Two,

which concluded that families responded to fluctuations in drinking but that the nature of that response varied.

Finally, it is worth noting that among the treatment completers returning measures at time three, APQ scores had decreased significantly from baseline (see Table 3.25), suggesting that, at the very least, participants' explicitly alcohol-related relationship and family problems had changed in a consistent direction – for the better.

Table 3.25: Alcohol-related problems: Pre-post comparison using paired samples t-tests

| <b>Variable</b>           | <b>Mean difference<br/>(pre-post)</b> | <b><i>t</i></b> | <b><i>df</i></b> | <b><i>p</i><br/>(2-tailed)</b> |
|---------------------------|---------------------------------------|-----------------|------------------|--------------------------------|
| APQ Marital score (n=6)   | 5.000                                 | 5.00            | 5                | .004**                         |
| APQ Children score (n=13) | 1.154                                 | 2.18            | 12               | .050**                         |

## Chapter Four: Study 2 – Methodology & Results

### Aims

While the secondary aim of Study 1 was to investigate perceptions of family change across the rehabilitation process, its quantitative methodology had several limitations. The small number of participants remaining in treatment and in the study across all three time points limited the conclusions that could be drawn from the data, as did the fact that only patient perspectives were represented. Additionally, there is some evidence that quantitative data does not describe the changes in family process during the transition to sobriety as well as qualitative data – in a cross-sectional study of alcohol patients and their partners at different stages of the recovery process, Rouhbakhsh, Lewis and Allen-Byrd (2004) found no differences in quantitative reports of family functioning by stage of recovery, even as clear differences in family process emerged during interview. Study 2 was thus designed to further investigate how the family changes during the residential rehabilitation process by speaking directly to alcohol patients and their family members about their experiences.

### Design

Study 2 was the qualitative component of the mixed methods design utilised by this thesis. Two parallel interview studies were conducted exploring family process before, during and after a residential rehabilitation stay: one with a sample of former alcohol inpatients and another with a sample of family members who had had a relative complete residential treatment. This allowed family change to be examined from both a patient and a family perspective, which was not possible in the quantitative study.

Interviews were guided by grounded theory methodology (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Grounded theory is a data-driven method for generating hypotheses and ultimately theories about poorly understood processes. As family process during the transition to and from residential rehabilitation has not previously been directly studied, it was important to choose a method that allowed for the identification of common themes and experiences in the population without restricting the scope of the discussion to the researcher's existing hypotheses. Grounded theory uses inductive rather than deductive reasoning, and through constant alternation between data collection and analysis, allows a working understanding of the process to be developed which is then refined through subsequent interviews. Other qualitative methods considered for use in this thesis either (1) relied on structured or semi-structured interviews to narrow respondents' focus, often to explore a specific hypothesis (e.g. content or thematic analysis) or (2) attended to the meaning participants made of their experiences rather than elaboration of process (e.g. interpretative phenomenological analysis or case studies). This meant these methods were less appropriate for Study 2 than a grounded theory approach, described in detail below.

As conceptualised by its original authors (Glaser & Strauss, 1967), grounded theory was a methodology firmly positioned in the positivist tradition. Investigators were observers, ideally with no pre-existing knowledge of the phenomena under study, who aimed to "discover" knowable realities. Constructionist grounded theory, a revision promoted by Charmaz (2006) and used in this thesis, acknowledges that even the most objectively collected observations are organised and interpreted subjectively by the investigator. Researchers using constructionist grounded theory explicitly consider their pre-existing ideas in order to understand how they may impact upon the interview process



and interpretation of the data, while allowing themselves to be led by participants. They also consider the investigator's experience of the interview as relevant data for analysis.

Both classical and constructionist grounded theory agree on a basic methodology. Initial interviews begin with general, open-ended questions designed to elicit discussion of the process under investigation. Interviewers are careful not to lead participants, allowing them to present content that is relevant to the topic based on their personal experience. Immediately after each interview, transcripts are coded at a micro, line-by-line level by attaching gerunds ('-ing' verbs) to each unit of text, drawing the researcher's attention directly to the action of the process being studied. As more interviews are conducted, these line-by-line codes are organised into descriptive categories that summarise participants' experiences and interpretations, moving the analysis from the literal to the conceptual. Coding becomes more focused as ongoing interviews address the emerging categories directly, relationships between the categories are explored, and a theory ultimately generated to describe and explain the process in question. Assumptions about the generalisability of the theory are derived from the diversity of the sample. (For a full description of the procedure used in Study 2, please see below.)

The current study is guided by constructionist grounded theory principles but adapts the methodology to the needs of a time-limited doctoral research project. The end result of the study may be considered a hypothesis, a preliminary step in the direction of a fully developed grounded theory. The latter requires continued interviewing across a diverse sample to verify the extent of its applicability.

### Recruitment of partner organisations

As the current study was not associated with an existing programme of research, a network of study sites needed to be established before participant recruitment could begin.

Chapter Three details the process of recruiting host organisations as well as identifying and preparing key contacts within these services to facilitate participant recruitment. Six residential rehabilitation centres agreed to host the study (see Table 3.1). That all six were in the private and voluntary sectors reflects local authorities' movement toward separating rehabilitation from detoxification when commissioning alcohol services, and funding these services outside the NHS.

### Sample size

Grounded theory makes a distinction between initial and theoretical sampling (Charmaz, 2006). The former is used to establish thematic categories in data gathered from a specific group of people, while the latter uses purposive sampling to develop these categories until they robustly describe the process in question. Sample size for both phases is driven by the data, and the idea of saturation (i.e. collecting data until no new ideas emerge), customary in qualitative methods, is relevant only in theoretical sampling. Sample size for initial sampling is based on the number of interviews it takes for themes to appear in the data of a relevant group.

In a study of sixty interviews with a homogenous sample, Guest, Bunce and Johnson (2006) found that overarching themes began emerging within six interviews. The current study found emerging themes after the first five interviews, and continued to sample until there were 10 participants in each group. This allowed interviews 6-10 to be directed toward the emerging themes, leading to the development of theoretical categories. Because Study 2 was part of a time-limited doctoral project, data collection ended at this point. Were the study to have continued, the categories would have been subject to exhaustive theoretical sampling, making theory development possible. The current cohort of interviews offers instead a direction for continuing research: a set of hypotheses about

what a grounded theory of family process during alcohol rehabilitation might look like, to be tested in further interviews.

### Recruitment of participants

Study 2 aimed to interview a sample of former alcohol patients and a sample of family members subject to the following inclusion criteria: (1) patients (including the relatives of the family sample) had to have completed a residential rehabilitation programme at least one month before the interview date, (2) alcohol must have been the primary substance for which the patient or relative was seeking treatment. Cognitive impairment which prevented interview made both patients and family members ineligible for the study. A range of recruitment strategies were utilised in order to obtain a sufficient sample. These are summarised below.

*Recruitment during rehabilitation.* The original recruitment plan was to approach patients at the end of their rehabilitation programmes to arrange interviews for one month post-discharge. Patients would be asked to discuss the study with relevant family members, who could agree to be contacted separately if interested in participating. Contact with patients was to be made by personnel at the study sites, who preferred to identify and approach suitable candidates themselves rather than have the researcher recruiting on site. In the private sector, this was to minimise outsider access to patients; in the voluntary sector, longer programmes with less turnover meant that it was more efficient for programme staff to alert the researcher when suitable candidates were approaching the end of treatment.

In the end, no patients or family members were recruited through this channel. Staff at Rehabilitation Centre A and Rehabilitation Centre F did not engage despite managerial support for the project and frequent attempts by the researcher to initiate

recruitment at these sites. Rehabilitation Centres D and E, both requiring a minimum residential stay of 12 weeks, had low turnover and smaller patient numbers; despite monthly telephone check-ins to monitor recruitment, no participants came from either site. Rehabilitation Centre E closed during the course of the study and Rehabilitation Centre D did not have any suitable candidates completing treatment during the recruitment period. Staff at Rehabilitation Centre C were responsive to weekly telephone enquiries about potential participants, but as the site was added towards the end of the project, no suitable candidates emerged during its short time in the study. This left Rehabilitation Centre B as the only productive study site. Though recruiting patients during their residential programmes was unsuccessful there as well, the recruitment channels below produced the full sample for Study 2.

*Recruitment during aftercare.* After discharge from Rehabilitation Centre B, former patients are entitled to aftercare services for up to one year. The facilitator of the weekly London-based aftercare group regularly presented the study to former patients and their relatives who met the inclusion criteria. Interested parties were given the participant information sheet (see Appendix 3) and consented for their contact details to be given to the researcher, who then phoned them to discuss the study and make an appointment for interview.

*Recruitment through family programming.* Three times a year, Rehabilitation Centre B offers a five day residential programme for family members and friends dealing with addiction. At the end of the 2014 summer session, the programme facilitator presented the study to participants, handed out the participant information sheet (see Appendix 4) and collected contact details from those willing to be interviewed. The

researcher then called interested parties to verify that they met the inclusion criteria, answer any questions they had and schedule times for interview.

*Recruitment at annual reunion.* Each year Rehabilitation Centre B holds a summer reunion for former service users and their families. A booth was set up for recruitment purposes at the 2014 event, where interested parties could read the participant information sheet and speak directly with the researcher about the study. Former service users and their relatives as well as former attendees of the residential family programme could then leave their contact details with the researcher who rang them later to verify eligibility.

*Recruitment through Study 1.* The final mechanism for recruitment into Study 2 was via Study 1. Participants who completed residential treatment while enrolled in Study 1 were sent the participant information sheet for Study 2 along with their time three questionnaire battery at one-month follow-up. Subjects were reminded that they were under no obligation to participate in Study 2; they were advised to contact the researcher if they were interested in being interviewed. Two participants participated in both studies.

## Procedure

*Interviews.* Interviews were 45 minutes in length and were primarily conducted in person. Telephone or Skype video interviews were available for participants who lived outside the greater London area. Table 4.1 summarises the interview formats used across the sample. Of those subjects interviewing in person, the majority were offered home visits (10 of 14); the remaining four were patients recruited through Rehabilitation Centre B's aftercare programme who were interviewed on site after their weekly group meeting. All interviews were audio recorded with participant consent.

Table 4.1: Summary of participant interview formats

| <b>Interview Type</b> | <b>Patient Sample</b> | <b>Family Sample</b> |
|-----------------------|-----------------------|----------------------|
| In person             | 8                     | 6                    |
| By phone              | 2                     | 2                    |
| Via Skype video       | -                     | 2                    |

Interviews were one-on-one with a researcher. Patient interviews 1-7 and family interviews 1-8 were conducted by advanced clinical trainees in the MSc programme in family therapy at the Institute of Psychiatry, Psychology and Neuroscience, King's College London, under the supervision of the author. Trainees were instructed in the essentials of conducting grounded theory interviews before starting and received supervision after every interview in order to ensure fidelity to the method and to process emerging themes (see section below). As the trainees did not have pre-existing specialist knowledge or close personal experience of alcohol dependence or recovery, they were particularly suited to grounded theory interviewing, which at the least requires declaration and elaboration of existing biases (i.e. constructionist grounded theory) and at most requires complete ignorance of the subject under study (i.e. classical grounded theory). Each trainee was responsible for one sample so as to understand the experiences of patients and family members separately; this also ensured interviewing in one group would not be led by data emerging from the other. Patient interviews 8-10 and family interviews 9 and 10 were conducted by the author.

As this thesis utilises constructionist grounded theory principles, initial preconceptions about what might be thematically important were elaborated before starting interviews and can be found in Table 4.2 below. These were derived from the author's personal and professional experience of alcohol dependence and its impact on family life, as well as familiarity with relevant literature. All interviewers were aware of these themes

and sensitive to their appearance during interviews, but were instructed to be led first and foremost by participants' own descriptions of the alcohol rehabilitation process.

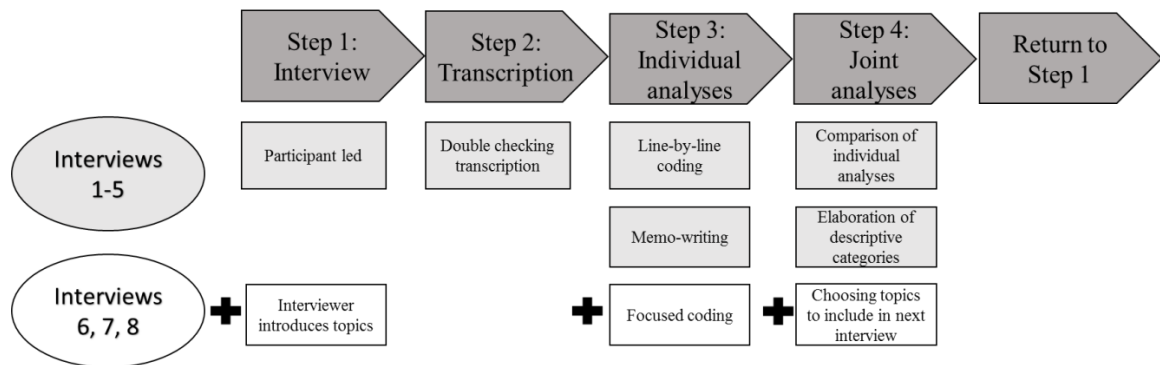
Table 4.2: Potential themes: Initial preconceptions defined in advance of data collection

|                              |   |
|------------------------------|---|
| <b>Before rehabilitation</b> | <ul style="list-style-type: none"> <li>• Family functioning (rules, roles, expectations)</li> <li>• Individual functioning &amp; other salient problems</li> <li>• Readiness to change</li> <li>• The family's role in effecting change</li> <li>• Perceptions of responsibility</li> </ul>   |
| <b>During rehabilitation</b> | <ul style="list-style-type: none"> <li>• Relative's absence from the home</li> <li>• Changes in family functioning (rules, roles, expectations) during this time</li> <li>• Changes in individual functioning &amp; other salient problems</li> <li>• Expectations for reintegration period ('action plan' for dealing with alcohol issues)</li> </ul>  |
| <b>After rehabilitation</b>  | <ul style="list-style-type: none"> <li>• Reality of reintegration period</li> <li>• Ideas about instrumentality – what is the family's role in maintaining abstinence?</li> <li>• Changes in family functioning (rules, roles, expectations) during this time</li> <li>• Changes in individual functioning &amp; other salient problems</li> <li>• Beliefs about treatment outcome (factors influencing success/failure)</li> </ul> |

Interviews began with informed consent (see Appendices 5 and 6), and then the interviewer asked the subject to “discuss life in your family before, during and after alcohol rehabilitation.” They were told they would have approximately 15 minutes to talk about each phase of the process. The first five interviews in each sample were completely participant led, with interviewers displaying curiosity and providing encouragement but leaving the burden of generating content to interviewees. Emerging themes were discussed during supervision after each interview (see section below) but were not directly raised with participants until interviews 6-10, at which point participant narratives were interrupted at appropriate points to query the developing themes.

*Post-interview analysis.* One of the hallmarks of grounded theory methodology is its constant alternation between data collection and analysis (Charmaz, 2006). An illustration of how this process functioned in the current study can be found in Figure 4.1. Interviews (Step 1) were conducted as described above, and Steps 2-4 are described below.

Figure 4.1: Recursive relationship between data collection and analysis, interviews 1-8



Immediately after each interview, the interviewer transcribed the audio recording of the session and sent it to the author, who double checked it against the recording for mistakes (Step 2). The final version of the transcript was then coded separately by both the interviewer and the author using QSR International’s NVivo software, Version 10 (2012) (Step 3). NVivo allows users to assign multiple codes to each line or section of text, and tracks the pattern of coding within and across interviews. The first round of coding, known as line-by-line coding in grounded theory, attached gerunds (‘-ing’ verbs) to each section of text. Codes such as “fearing for the future” and “prioritising recovery” distilled participants’ narratives into explicitly labelled actions, allowing an overall picture of the process to develop.

Across interviews, frequently occurring line-by-line codes were condensed into descriptive categories through the processes of memo-writing (Step 3) and discussion (Step 4). Memo-writing, a practice specific to grounded theory methodology, is a mechanism



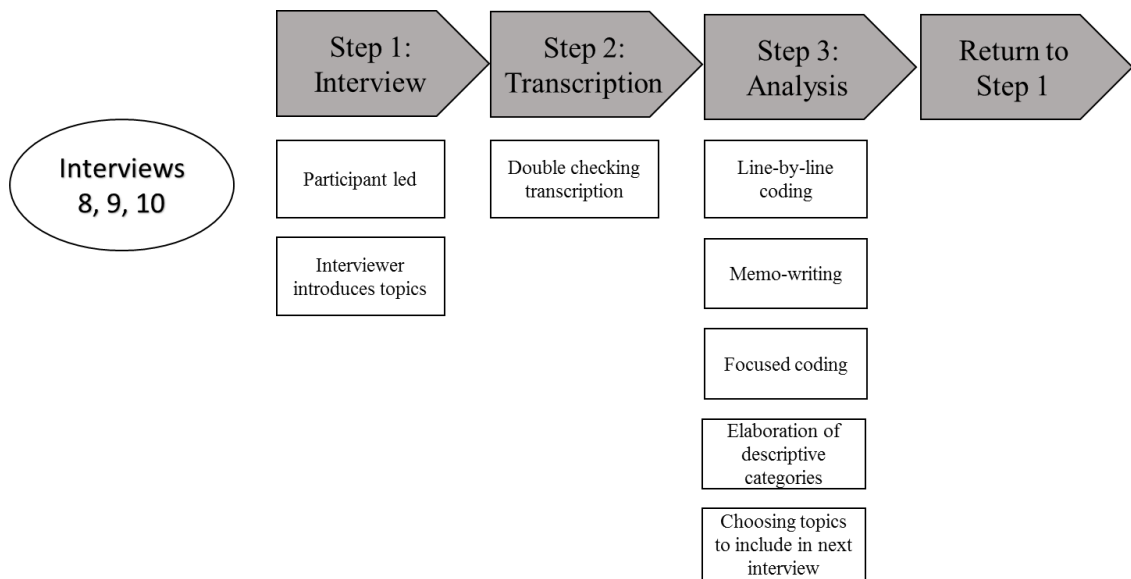
for making connections between codes, and eventually across categories and interviews, by recording one's thoughts, observations and ideas after each encounter with the data. From one interview to the next, and thus from memo to memo, the researcher subjects his or her developing views to continued analytical scrutiny, incorporating the content and coding from the latest interview into the emerging descriptive categories.

Both the interviewer and the author engaged in memo-writing alongside the coding of each transcript. After each interview and before the next, they met for supervision (Step 4) and shared their hypotheses about the process based on their memos and line-by-line coding. This accountability to each other helped both to stay data driven, stopping either from being led by their experience or preconceptions. For the course of the first five interviews, memos and supervision were focused on the patterns in the line-by-line coding that would become the descriptive categories.

After the first five interviews, descriptive categories were substantial enough to be coded in their own right, and to be introduced directly into interviews. From interview 6 onward, coding was increasingly focused; line-by-line coding of gerunds continued but was less comprehensive as whole sections were now coded into the emerging descriptive categories. Post-interview supervision continued to address the development of the categories, but was now also used to identify which specific themes should be addressed directly in the next interview.

The final interviews in each sample (P8-10, FM9-10) were conducted and analysed by the author once the trainee family therapists had finished their work on the project (see Figure 4.2 below). By that point specific descriptive categories had been established and interviews focused simply on developing them further, with memo-writing and coding continuing to drive this process.

Figure 4.2: Recursive relationship between data collection and analysis, interviews 8-10



The final stage of the project was to develop a hypothesis to explain the relationship between the descriptive categories, a step towards the articulation of a true grounded theory. Earlier interviews were revisited and re-analysed by the author to assess their fit within this final theoretical framework.

#### Ethics and R&D approvals

This project was reviewed by the South East London Research Ethics Committee and received a favourable opinion on 29 May 2013. It was amended three times on account of design changes (substantial amendments approved on 15 July 2013 and 7 December 2013, minor amendment approved on 10 July 2014).

The primary ethical concerns were the same as for Study 1: (1) possible participant distress due to the sensitive content of interviews and (2) handling potential disclosures. As described in Chapter Three, both of these risks were managed first and foremost by having trained clinicians as interviewers. (Both trainee family therapists already had a primary clinical qualification.) To manage the risk of participant distress, subjects were given the researcher's contact details for follow-up if necessary; one participant used this

channel to request referral for further services. Interviewers were prepared to report abuse or neglect as a result of participant disclosure, and consent forms and information sheets made the limits of confidentiality explicit to subjects. In the event, no disclosures were made, and reporting was not necessary.

Once recruitment and data collection began, several amendments to the research protocol became necessary. As described in Chapter Three, these changes were a response to the ways in which the original study design proved incompatible with the reality of the treatment context. As in Study 1, the first major change was to the inclusion criteria. It was originally planned that interviews would be with a paired sample of patients and their partners. In practice, however, this restricted the number of subjects that could realistically be recruited, as only intact couples were eligible, and both parties needed to agree to participate. Opening up the inclusion criteria to unpaired samples of patients and family members (not simply partners) improved recruitment and created a sample that more closely reflected the diversity of relationships in the population under study. It also allowed family members to be recruited independently of patients, which led to further changes to the protocol.

Finally, amendments were made to introduce telephone/Skype interviewing, allowing participants from outside greater London to take part in the study. This also helped researchers to make participation as convenient as possible for potential interviewees, further reducing the barriers to recruitment.

### Sample characteristics

The sample for Study 2 consisted of two groups of interviewees: (1) former alcohol inpatients and (2) family members who had had a relative complete residential treatment. Four of the alcohol patients in group one had a corresponding partner or family member

interviewed in group two. The other 6 patients and family members were unconnected.

Two of the family members in group two were from the same household (their qualifying relative was not interviewed). As data from patients and family members were analysed separately in order to understand each group's particular experience, only the latter pairing introduces any data dependency into the sample.

Tables 4.3-4.6 describe the 10 alcohol patients interviewed in Study 2. Table 4.3 summarises key demographic information for this group, which was 70% male and 90% white, with an average age of 49.6 years (range = 32-65 years). Sixty percent were unemployed. This means the sample approximates the patient population nationally, where, according to the 2014 National Drug Treatment Monitoring System, 64% of clients in alcohol services were male, 92% were white and the median age was 43 years (Public Health England, 2014a). While the goal of grounded theory methodology is not to create a representative sample but rather to include cases that advance the developing theoretical argument, it is still important in the initial sampling phase to deliberately choose a relevant sample to start from.

Table 4.3: Demographic data, alcohol patient sample

| <b>Participant ID</b> | <b>Age</b> | <b>Gender</b> | <b>Ethnicity</b> | <b>Occupation</b>       |
|-----------------------|------------|---------------|------------------|-------------------------|
| P1                    | 53         | F             | White            | Unemployed              |
| P2                    | 65         | M             | White            | Unemployed              |
| P3                    | 45         | F             | White            | Unemployed              |
| P4                    | 35         | M             | White            | Unemployed              |
| P5                    | 65         | M             | White            | Unemployed              |
| P6                    | 55         | M             | White            | Interim manager         |
| P7                    | 42         | M             | White            | Nightclub proprietor    |
| P8                    | 49         | M             | White            | Investment fund manager |
| P9                    | 55         | M             | White            | Unemployed              |
| P10                   | 32         | F             | Asian            | Medical doctor          |

Table 4.4 below describes the rehabilitation experience of the 10 alcohol patients, who spent an average of 7 weeks away from home in residential treatment. Eight of the 10 interviewees were enrolled in private treatment programmes (at Rehabilitation Centre B and elsewhere); two others were funded by their local authorities to attend longer, 12 week programmes in the voluntary sector. At interview, the median time since treatment completion was 2.83 months. All but one of the former patients were maintaining abstinence at the time of the interview.

Table 4.4: Rehabilitation programme information, alcohol patient sample

| <b>Participant ID</b> | <b>Type of centre</b> | <b>Length (wks)</b> | <b>Months since completion</b> | <b>Alcohol use at time of interview</b> |
|-----------------------|-----------------------|---------------------|--------------------------------|---|
| P1                    | Private sector        | 6                   | 6.97                           | Lapsed, but abstaining                  |
| P2                    | Voluntary sector      | 12                  | 2.73                           | Relapsed to alcohol use                 |
| P3                    | Private sector        | 6                   | 1.37                           | Maintaining abstinence                  |
| P4                    | Voluntary sector      | 12                  | 2.37                           | Maintaining abstinence                  |
| P5                    | Private sector        | 6                   | 3.50                           | Maintaining abstinence                  |
| P6                    | Private sector        | 4                   | 22.03                          | Maintaining abstinence                  |
| P7                    | Private sector        | 6                   | 1.93                           | Maintaining abstinence                  |
| P8                    | Private sector        | 6                   | 2.93                           | Maintaining abstinence                  |
| P9                    | Private sector        | 6                   | 1.67                           | Maintaining abstinence                  |
| P10                   | Private sector        | 6                   | 9.20                           | Maintaining abstinence                  |

Table 4.5 and 4.6 describe the family and living situations reported by interviewees in the patient sample. Seven of the 10 participants had a current partner, and though two of these were estranged, the relationships were on average 22.29 years in length. Eight interviewees were parents to a total of 19 children, the majority (73.7%) under 18 years old. Those with children under 18 reported sharing a home with them either some or all of the time.

After rehabilitation, all but two participants returned to a family system. Of these eight patients, two moved in with parents and six went back to partners (four of these to both partners and children). Several participants (P2, P4, P8) moved between living

situations, alternating between living alone or with a parent and staying with partners and children. All participants were in regular contact with family members, even those living alone.

Table 4.5: Family relationships, alcohol patient sample

| <b>Participant ID</b> | <b>Marital Status</b>            | <b>Length of current relationship</b> | <b>Number of children (ages at time of interview)</b> |
|-----------------------|----------------------------------|---------------------------------------|---|
| P1                    | Married                          | 18 years                              | 3 (15, 10, 9)   |
| P2                    | Married, but separated           | 37 years                              | 1 (33)  |
| P3                    | Married                          | 22 Years                              | 2 (17, 14)  |
| P4                    | In a relationship, but separated | 24 years                              | 5 (17, 14, 10, 8, 2)                                  |
| P5                    | Divorced                         | -                                     | 2 (35, 31)  |
| P6                    | Divorced                         | -                                     | 2 (21, 20)  |
| P7                    | Married                          | 10 years                              | 1 (8)   |
| P8                    | Married                          | 15 years                              | 3 (15, 13, 11)  |
| P9                    | Civil partner                    | 30 years                              | -   |
| P10                   | Single                           | -                                     | -   |

Table 4.6: Living arrangements post-rehabilitation, alcohol patient sample

| <b>Participant ID</b> | <b>Living arrangements after rehabilitation</b>                        |
|-----------------------|--|
| P1                    | Lives with husband and children  |
| P2                    | Lives with wife 2-3 days per week, in own flat the rest of the time    |
| P3                    | Lives with husband and children  |
| P4                    | Lives with mother but occasionally stays with children                 |
| P5                    | Lives alone  |
| P6                    | Lives alone, with children when home from university                   |
| P7                    | Lives with wife and children   |
| P8                    | Alternates between the family home with wife and children and own flat |
| P9                    | Lives with partner   |
| P10                   | Lives with parents   |

Tables 4.7-4.9 describe the 10 family members interviewed in Study 2. Table 4.7 summarises key demographic information for this group, which was 70% female and 100% white, with an average age of 46.6 years. These summary statistics belie the

diversity of this small sample, however. The wide age range of participants (range = 21-75 years) is one indicator of the mix of relationships represented, which includes the parents, partners, siblings and children of former residential alcohol patients. Though most samples of this population consist primarily of female partners and mothers (Orford, Velleman, et al., 2010), these two groups make up only 50% of the current sample.

The diversity of relationship types represented in the initial sampling phase allowed experiences common to all family members to emerge in interviews, moving us toward explication of those aspects of the alcohol rehabilitation process that are universal. This may, however, have been at the expense of identifying experiences specific to individual relationships (i.e. to parents, partners, or children).

Table 4.7: Demographic data, family sample

| <b>Participant ID</b> | <b>Relationship to patient</b> | <b>Age</b> | <b>Gender</b> | <b>Ethnicity</b> | <b>Occupation</b> |
|-----------------------|--------------------------------|------------|---------------|------------------|-------------------|
| FM1                   | Husband                        | 55         | M             | White            | Theatre director  |
| FM2                   | Sister                         | 23         | F             | White            | Care worker       |
| FM3                   | Mother                         | 52         | F             | White            | Receptionist      |
| FM4                   | Husband                        | 49         | M             | White            | Investment sales  |
| FM5                   | Son                            | 21         | M             | White            | Student           |
| FM6                   | Wife                           | 75         | F             | White            | Lecturer          |
| FM7                   | Daughter                       | 33         | F             | White            | Actress           |
| FM8                   | Wife                           | 48         | F             | White            | Unemployed        |
| FM9                   | Mother                         | 63         | F             | White            | Retired           |
| FM10                  | Wife                           | 47         | F             | White            | Unemployed        |

Table 4.8 below demonstrates that, like the patient sample, all but two of the family members interviewed lived with their alcohol dependent relative and thus were directly involved in the transition to and from rehabilitation. Unlike the patient sample, however, the majority of family members were employed and had to balance their professional responsibilities with the challenges of alcohol misuse and recovery at home.

Table 4.8: Living arrangements post-rehabilitation, family sample

| <b>Participant ID</b> | <b>Living arrangements after rehabilitation</b>                          |
|-----------------------|--|
| FM1                   | Lives with patient and children  |
| FM2                   | Lives with patient   |
| FM3                   | Lives with patient   |
| FM4                   | Lives with patient and children  |
| FM5                   | Lives at university; stays with patient during school holidays           |
| FM6                   | Lives with patient   |
| FM7                   | Lives alone  |
| FM8                   | Lives with patient and children  |
| FM9                   | Lives alone  |
| FM10                  | Lives with children; patient alternates between family home and own flat |

Table 4.9 describes the rehabilitation experiences of the alcohol dependent relatives of the family sample. Nine of the 10 relatives attended similar programmes, spending an average of 5.56 weeks away from home in private sector residential services, after which they maintained abstinence. The son of FM9 is the exception: after being away for 24 weeks in a voluntary sector programme, he relapsed and returned to alcohol use.

Participants in the family sample were interviewed further from discharge than those in the alcohol patient sample (median time 7.57 vs. 2.83 months post-discharge); this was a result of having less immediate access to family members for recruitment purposes during rehabilitation and aftercare.

Table 4.9: Rehabilitation experiences of alcohol dependent relatives, family sample

| <b>Participant ID</b> | <b>Type of centre</b> | <b>Length (wks)</b> | <b>Months since completion</b> | <b>Patient's alcohol use at time of interview</b> |
|-----------------------|-----------------------|---------------------|--------------------------------|---|
| FM1                   | Private sector        | 6                   | 7.30                           | Maintaining abstinence                            |
| FM2                   | Private sector        | 6                   | 1.27                           | Lapsed, but abstaining                            |
| FM3                   | Private sector        | 6                   | 1.27                           | Lapsed, but abstaining                            |
| FM4                   | Private sector        | 6                   | 3.03                           | Maintaining abstinence                            |
| FM5                   | Private sector        | 4                   | 22.30                          | Maintaining abstinence                            |



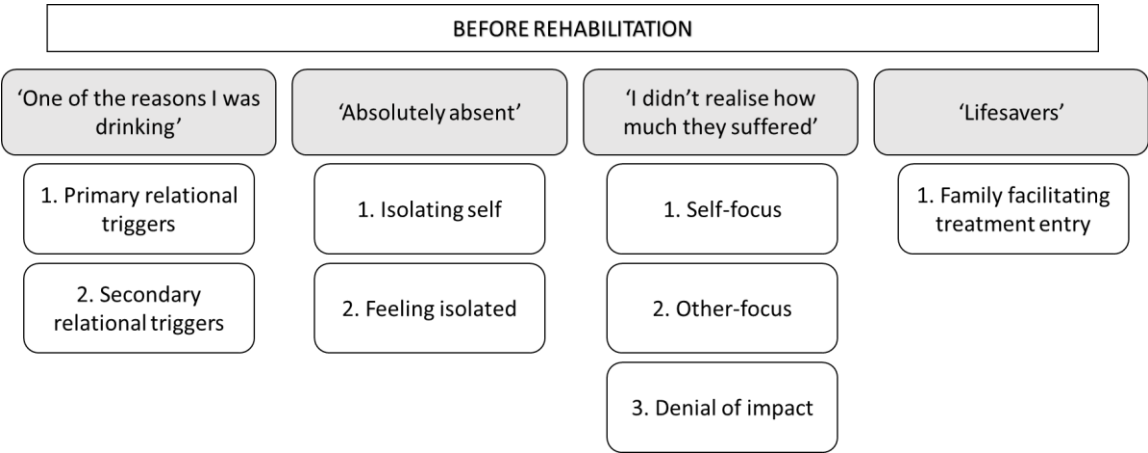
| <b>Participant ID</b> | <b>Type of centre</b> | <b>Length (wks)</b> | <b>Months since completion</b> | <b>Patient's alcohol use at time of interview</b> |
|-----------------------|-----------------------|---------------------|--------------------------------|---|
| FM6                   | Private sector        | 6                   | 11.47                          | Maintaining abstinence                            |
| FM7                   | Private sector        | 6                   | 3.97                           | Maintaining abstinence                            |
| FM8                   | Private sector        | 4                   | 9.43                           | Maintaining abstinence                            |
| FM9                   | Voluntary sector      | 24                  | 36.77                          | Relapsed to alcohol use                           |
| FM10                  | Private sector        | 6                   | 7.83                           | Maintaining abstinence                            |

As described above, grounded theory methodology embeds its conclusions in the specific sample used; generalisability is extended by testing the developing theory in future interviews with a variety of participants. Overall, the 20 people interviewed as part of Study 2 had a very similar experience of rehabilitation and recovery – patients and qualifying relatives overwhelmingly attended short-term, private sector programmes and were successful in maintaining abstinence after – which means that the next sampling phase, theoretical sampling, would have to include subjects who had had different experiences if the developing theory were to have applicability outside of the present cohort.

#### Results: Patient sample

As described above, interviews were divided into sections exploring family life before, during and after rehabilitation to identify common experiences and investigate change across the treatment process. These phases are presented in diagram format below, and then described in detail using direct quotations from participants. At the end of the section, the relationship between the categories in each phase is outlined, providing a hypothesis for a grounded theory of family change from patients' perspective.

Figure 4.3: Before rehabilitation: Categories describing patients’ experience



*Before rehabilitation.* Four overarching categories emerged from patients’ accounts of life before alcohol rehabilitation, each containing a number of subcategories. Category names are taken from participants’ own accounts. The first category, ‘One of the reasons I was drinking,’ describes how patients consistently identified relational issues as triggers to alcohol use, highlighting the interconnectedness of the alcohol patient and their family system. The second category, ‘Absolutely absent,’ details the ways in which patients’ isolation from their families and partners – either self-imposed or perceived – was critical to their patterns of consumption. Category three, ‘I didn’t realise how much they suffered,’ explores how patients understood the impact of active drinking on family members. Finally, category four, ‘Lifesavers,’ describes how family members overwhelmingly facilitated treatment entry.

*‘One of the reasons I was drinking.’* Consistent with the literature on predictors of relapse to alcohol use, nine of the ten interviewees described drinking to manage stress or mood. The interview format used in the current study, however, allowed participants to elaborate on the particular stressors driving consumption: family and relational factors were mentioned in seven of the ten interviews. Of these, four participants described how

family and relational factors were the primary trigger for use while three others explained how family factors exacerbated an existing problem.

The four patients whose drinking was driven by relational factors described the common experience of feeling trapped in their relationships or by their family situations. They drank very consciously to escape or avoid the context in which they found themselves. For two participants, this was a relationship they did not want to be in, in which they felt their true selves suppressed. For another, it was a family he'd never wanted to build in a country he'd planned to leave. For the last, it was coping with the needs of a disabled child in the face of an unsupportive husband. All four of these patients explicitly connected their drinking to these situations.

The three participants who reported family factors as a secondary trigger described how patterns of drink fuelled by external stressors and low mood were exacerbated by their experiences at home. They described how feelings of anger, resentment, and guilt in the relational context led to further drinking: they drank to ignore the judgment of parents, the shame of having failed as parents themselves, and to quiet their anger at ex-partners. The importance of family factors as both primary and secondary triggers to alcohol use highlights the importance of the family context in establishing patterns of consumption; these patterns will need to be addressed if abstinence is to be successfully managed after discharge.

Box 4.1: 'One of the reasons I was drinking:' Quotes from patients

*"I stayed here and I now look back at it and it's a bit of resentment or whatever you may call it...I've stayed here for you and that's where it escalated from, when she was born. Other blokes would be top of the moon...I went the opposite. I didn't want a kid, I didn't want to stay around. I did, but in body, not up there." (P4)*

*"I guess it evolved nastily in the last few years before I first went into <Rehabilitation Centre B>, basically in my relationship with my wife...Basically I was building up a lot of*

*resentments about it, and it was my escape from those resentments and those emotions that I was living with basically on a day to day basis. I just couldn't handle at all.*" (P8)

*"I'd start by saying that...the problems I've had with alcohol and addiction have been fuelled by a particular relationship where I live at home."* (P9)

*"To avoid him, I just couldn't stand it, I would go out and get drunk."* (P9)

*"They are open minded and quite liberal but I could still just sense what she was thinking and that would just make me drink even more just to kind of ignore it."* (P10, referring to her mother)

*'Absolutely absent.'* For the majority of the sample (9 of 10 interviewees), an integral aspect of family life before rehabilitation was the experience of isolation. For some participants, this isolation was the result of heavy drinking and was understood to be self-imposed. Patients described sleeping excessively, intentionally withdrawing from family life both physically and emotionally, and avoiding their relatives and partners. They felt isolated by the simple fact of being alcohol dependent, which they felt their family members could not understand, and the measures they took to hide their condition introduced still more distance into their relationships.

For other participants, perceived isolation from friends and relatives was a trigger to drink and felt imposed upon them by circumstance. In several cases this was the result of physical isolation from family and friends due to relocation, divorce, or work abroad. In still more cases, however, this was the result of emotional isolation: feeling misunderstood, unheard, or unwanted in the context of family or intimate relationships. This emotional isolation was compounded in periods of high stress when the need for emotional support was paramount.

Box 4.2: 'Absolutely absent:' Quotes from patients

*"Occasionally I used to go around there and they used to see me, like, as I say, asleep like midday over the weekend. I would just sleep all day then disappear again." (P4)*

*"Throughout my marriage I have felt very disconnected to him because he's just, emotionally, he's just been on his own mission and he hasn't needed you know...he's sort of in a box and he hasn't needed anything but he hasn't given anything either. So where I needed perhaps some support and some emotional help, he wasn't there." (P3)*

*"You go very much into yourself and want to be by yourself, and also want to be with other people that are also drinking and using as well...It's both really isn't it, you don't want to be there and they don't want you around them, do they?" (P7)*

*'I didn't realise how much they suffered.'* The third category describing life before rehabilitation concerns how patients perceived the impact of their drinking on family members and on the family system as a whole. When prompted to discuss family life at this period, patients overwhelmingly recounted a narrative of their personal addiction experience. As part of this process, interviewees were sometimes able to acknowledge what they perceived as personal failings in the family context (e.g. sleeping too much, not taking children for days out), but did so without connecting these explicitly to specific repercussions for family members. Only in three cases was this self-focus interrupted by an other-focused recognition of impact or an acknowledgment of the wider systemic effects of their alcohol use. In these cases, participants reported feeling shame at having upset family members; one participant was able to recognise that her eldest daughter had become parentified. Importantly, in six of the ten interviews participants denied that their drinking had any impact at all on their family members (n=4) or reported that they had not realised the impact until much later in the treatment process (n=2).

#### Box 4.3: 'I didn't realise.' Quotes from patients

*"I left the children – and my two youngest children were then and are still 9 and 10 – not really knowing what was going on and my eldest child, who is 15, doing what she had been doing for some months before which was feeling she was holding the fort and being the responsible one and...parenting me to a certain extent. And I think I left her an absolute mental wreck." (P1)*

*"I don't know what the impact I had on my children really was. All I can say is that, you know, I wasn't eaten up by shame and guilt by what I was doing to them." (P6)*

*"It's something that I found out about afterwards. Really, you don't realise the extent of the problems that you've caused until later, cause when you're in the middle of active addiction you don't really give a fuck about, excuse my language, you don't really care about anybody else other than yourself, do ya?" (P7)*

*"The family were actually ok to be honest and they really weren't affected from it." (P8)*

*'Lifesavers.'* Category four explores family members' role in the transition to rehabilitation. Eight of ten interviewees described how their partners or relatives facilitated treatment entry. In six of these cases, family members staged a deliberate intervention, either organising treatment themselves or issuing an ultimatum to patients. Overall, family members overwhelmingly took responsibility for the practical details of the transition: arranging and accompanying the patient to medical appointments, packing for them, organising their homes and apartments, transporting patients to their rehabilitation programmes and caring for children and partners left behind. This contribution is especially salient in the face of the relational stress, isolation and self-focus described in the previous categories.

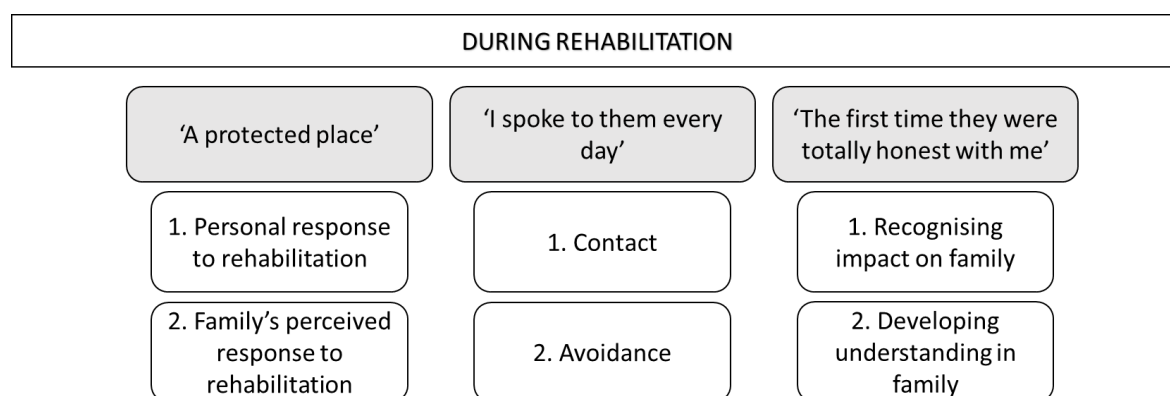
#### Box 4.4: 'Lifesavers:' Quotes from patients

*"It was arranged for me. It was arranged how I'd get there, I didn't really need to think about anything, and my sister packed and I was taken there. I was quite an invalid really." (P1)*

*“I felt that if there was a god above he would take me and I wouldn’t give a monkey’s...I was in that state there where you don’t care anymore...It was only when my wife and daughter were coming over and said, right, you’ve got to do something.” (P2)*

*“And they came to see me and they said we want to talk to you and I said yes, so, well, go ahead...And they said we’re worried about your drinking, we think you’re drinking far too much, and we have made arrangements for you to go into a clinic if you’re willing to go. And so I agreed.” (P5)*

**Figure 4.4: During rehabilitation: Categories describing patients’ experience**



*During rehabilitation.* Three overarching categories emerged from patients’ accounts of alcohol rehabilitation itself, each containing two subcategories. Again, category names are taken from participants’ own accounts. Category one, ‘A protected place,’ describes patients’ emotional response to residential rehabilitation as well as their ideas about what the experience was like for their families. Category two, ‘I spoke to them every day,’ explores how patients and their relatives managed distance while participants were in treatment. Finally, the third category, ‘The first time they were totally honest with me,’ illustrates the ways in which residential rehabilitation provided a space for the development of mutual understanding between patients and their families.

*‘A protected place.’* When participants were prompted to discuss family life during rehabilitation, they began by sharing their own experience of exchanging the family environment for the residential treatment context. While a few participants acknowledged

the emotional challenge that their programmes presented (e.g. having to face long-repressed feelings or confront painful experiences), the patients interviewed largely found the treatment transition to be a great relief. They spoke of escaping from lives that had gotten out of control, of being able to breathe and think clearly again. Four participants actually described a resurgence of what they called happiness.

When considering their families' experience of the time, however, only two participants explicitly addressed or empathised with the challenges faced by their relatives still at home. These two patients were cognisant of the anxiety and suffering they had left behind, and one took the opportunity to put in a plea for additional support for families in the rehabilitation context. Otherwise, the most common perception amongst participants of the family's experience during rehabilitation was that they were grateful and proud of patients' efforts. In this perspective, one can glimpse a continuation of the lack of other-focused recognition of impact that characterised patients' relationships before treatment.

Box 4.5: 'A protected place:' Quotes from patients

*"It was the first time that I felt I could actually sort of draw breath and think about what had really happened and what was going on rather than being in the thick of it and not knowing how to escape from it." (P1)*

*"After about a fortnight I suddenly realised I was laughing for the first time in ages...I had drunk to relax but this was just natural relaxing and feeling ok, I wasn't on any drugs." (P5)*

*"I was quite happy, I was actually quite happy to be away... 'cause I was getting out of a situation where all my resentments, my issues had arisen and to be in a protected place where I was away from it all was actually rather nice, to be honest." (P8)*

*"They were grateful in the way that they knew that Mummy was going to be sorted out, in terms of hopefully she wasn't going to cry, you know, every time she phoned her parents..." (P3)*



*'I spoke to them every day.'* While in residential rehabilitation, a majority of patients in the current sample (80%) maintained regular contact with their partners and relatives, who they perceived as supportive. Patients exchanged letters and phone calls with family members during treatment, and on allowed days, relatives also visited (despite the sometimes very large distances between home and the rehabilitation centre). For three patients, however, rehabilitation was a time for enforced distance from their romantic partners: in these cases, phone and in-person contact was deliberately avoided for the duration of the treatment period.

Box 4.6: 'I spoke to them every day:' Quotes from patients

*"My wife and daughter said 'Dad, we're pleased for you, terrific!' And they were visiting me down there as well and I was phoning them when we could." (P2)*

*"We used to talk, we used to phone 'em up, try to phone 'em up, a couple of times a week, write letters when I could pick the pen up...I was getting letters, they were saying they were missing me, they was proud of what I was doing, can't wait to have me back." (P4)*

*"She doesn't engage herself in any way with any of the treatment, she's never been to <Rehabilitation Centre B>, doesn't want to go to any meetings with any counsellors, doesn't want to engage in any of it." (P7)*

*"During my time there I said to him don't contact me. If it's desperate, this is the number." (P9)*

*'The first time they were totally honest with me.'* For a subset of the sample, the space provided by residential rehabilitation gave families and patients a chance to develop a deeper understanding of the other's experience. Three patients reported that it wasn't until they entered treatment that they realised the full extent of their impact on their children. In these cases, children finally felt safe enough in the rehabilitation context to share their feelings and experiences with their alcohol dependent parent. This disclosure was facilitated by family therapy in one instance and instigated by adult children in the

other two cases. Three other patients explained how family members used the separation to learn more about addiction and to engage with others who were going through similar experiences. Together, these six participants describe the potential for rehabilitation to be a connective space even as family members are physically separated from one another.

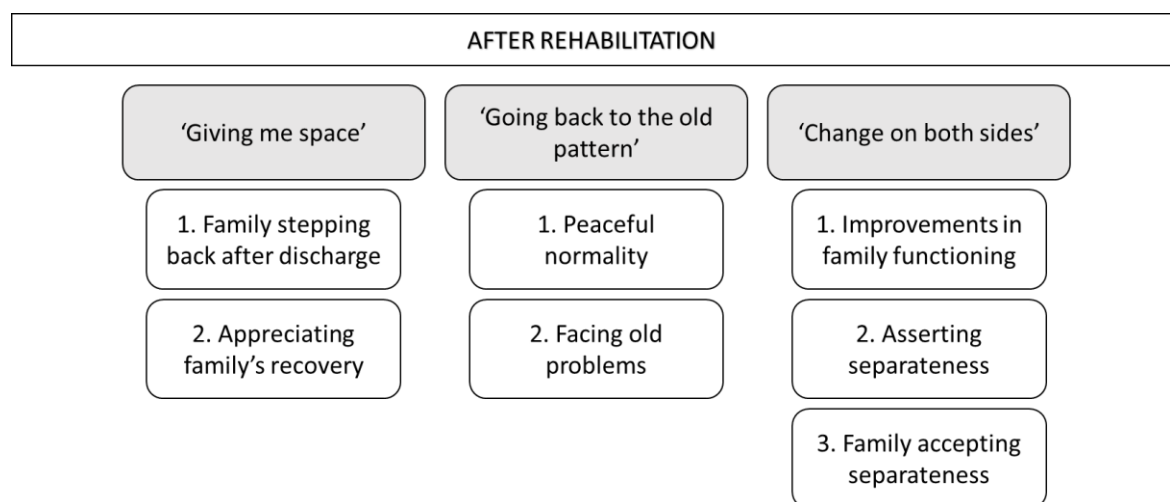
Box 4.7: ‘The first time they were totally honest with me.’ Quotes from patients

*“It put some kind of semblance of order or sense into it, something...I think in so far as they could relate to other family members of other people in the stories...like AA meetings...you relate, so it becomes less your own thing, it’s a recognized thing you’re going through, a recognized state.” (P1)*

*“It just gave the chance for the boys to explain what the experience had been like for them and C just said, ‘Mummy, I could never bring friends home because I didn’t know whether you were going to have a blip.’ Now of course that broke my heart, I cried my heart out.” (P3)*

*“It was difficult, because for the first time they were totally honest with me about how my drinking had affected their lives when they were younger and they said... ‘there are certain things we haven’t talked to you about because a) you wouldn’t have agreed to them, you wouldn’t see it from our point of view, and b) you might not be in a fit state to really take in what we were saying to you.’” (P5)*

Figure 4.5: After rehabilitation: Categories describing patients’ experience



*After rehabilitation.* Three overarching categories and several subcategories emerged from patients’ accounts of family life after discharge. The first category, ‘Giving

me space,’ describes how families managed distance in the immediate aftermath of rehabilitation. Category two, ‘Going back to the old pattern,’ illustrates both the positive and negative ways in which families resumed the status quo. Finally, category three, ‘Change on both sides,’ explores the sample’s most frequently cited relational changes after treatment.

*‘Giving me space.’* As treatment concluded, patients faced the challenge of transitioning back to everyday life and reintegrating into their family systems. Remembering their return home, several patients commented on the distance they perceived in their relationships. For some, it was the tentative, cautious behaviour of family members who weren’t sure what to expect or who feared relapse. Others noticed a stepping down of the deliberate, goal-directed support that had characterised the period before treatment entry. Several patients reported a lack of communication about the rehabilitation process in the family context. At the same time, however, a few participants acknowledged the reciprocal nature of this separateness, respecting relatives’ need to pursue their own recovery in parallel.

Box 4.8: ‘Giving me space:’ Quotes from patients

*“So I returned to a very tentative household. L was more than cautious and M, my 15 year old daughter, was suspicious and cross and the other little two were just delighted...so it was a sort of strange dynamic, people were tentative and so was I.” (P1)*

*“When I came out...now looking back on it...a decision clearly had been made to back off.” (P1)*

*“He never talked to me about meeting this new girlfriend and I think the reason for that was because he didn’t know how I’d be with her, you know, how I’d behave, what my manner would be like.” (P5)*

*“My youngest son, I offered to make amends to him and he just said ‘no, it’s ok, we don’t need to discuss it.’ You know, he hasn’t sort of really discussed it with me...he won’t.” (P6)*

*“Of course it is not only my recovery but absolutely theirs and that’s what they’re doing at the moment, and I’m very aware of that...you know, when people used to talk about ‘it’s a family illness,’ I’d think, ‘bullshit, it’s really not,’ but it really is.” (P1)*

*‘Going back to the old pattern.’* For some patients, returning home after rehabilitation meant resuming the status quo. Patients were divided when it came to this: there were positive feelings when a comfortable normality was reinstated but frustration and despair when problematic patterns recurred. These experiences were equally distributed in the current sample, suggesting that resumption of the status quo can often be as positive and protective as it is potentially destabilising.

In the positive instances, participants discussed resuming the routines of family life, and spoke gratefully of watching calm return to the family home. In some cases, previously estranged relationships were resumed, and patients talked of learning acceptance. In the negative instances, however, participants reported frustration at returning to family systems that had not changed alongside them. Old patterns of communication and dissatisfying interactions felt jarring, and patients were stuck in a double bind, powerless to change their relatives even as they felt themselves compromised by the environment.

Box 4.9: ‘Going back to the old pattern:’ Quotes from patients

*“I think that we just sort of now are getting on with it, it’s sort of the calm after the storm. It’s nice, it’s a nice time. We’re calm, and I’m calm.” (P1)*

*“I’m now sorting it out. Accepting who I am, accepting that I’m in this situation, accepting him in a way, that I can’t change him, he’s too old...So now it’s like, he came home last night from being out and I was like, rather than like scurrying into my room because he wants to debrief me of everything that happened in the evening...I just accept that he’s going to do that, I don’t mind anymore.” (P9)*

*“It seems like things are going back to the old pattern but not me – as the counsellor used*

*to say, when you're in there, don't forget that when you get out there you've changed but nothing else has, so don't go out expecting... I knew this anyway but it's definitely a shock. You're thinking differently, everyone else is just still carrying on doing what they're doing." (P4)*

*"Like I said to you before, it's never changed, we have a very cold relationship whereby we live together really for the sake of our daughter. That's it, she doesn't engage in the treatment, she doesn't want to know about it, very difficult relationship with my wife." (P7)*

*"It's the willingness of someone else to want to change with you or not. It's not all up to me to tell her...So it's sort of slightly out of your control in a way, I think." (P8)*

*'Change on both sides.'* In contrast to the last section describing the ways in which families stayed the same after rehabilitation, this final category explores the changes patients perceived in their family systems. Seven of the 10 patients interviewed described positive changes in one or more aspects of family functioning post-discharge. Renewed engagement in family life after a period of both physical and emotional absence led to improved relationships with children, and both quantity and quality of time spent together increased. With continued sobriety, participants noticed increased communication: family members seemed more able to discuss their concerns with patients, who in turn began to confide in their relatives. Conflict decreased at home as partners respected each other's space. Laughter returned to family life.

Crucially, in discussing the period after residential rehabilitation, participants often made reference to the ways distance regulation changed in the family. For many patients, there was a deliberate assertion of separateness as they pursued their recoveries, prioritising their own needs over those of the system. This stands as a contrast to the pattern before rehabilitation, when enduring seemingly oppressive relationships led to increased alcohol consumption. (It retains the self-focus of this earlier phase, however.) In response, participants found that their relatives accepted their separateness even where it

was not their preference. In the wake of this new reality, power dynamics shifted, and partners and family members were forced to give up some of the control patients perceived them as having held whilst they were drinking.

Box 4.10: ‘Change on both sides: Improvements’: Quotes from patients

*“From their side I feel that there’s more confidence in being able to be more communicative.” (P1)*

*“Since I’ve been back we’re talking a lot more, and getting on. Going down the coast with each other now and down the beach...I’m talking more, having a laugh with them more, talking about normal things instead of me just sitting there nodding me head.” (P4)*

*“There’s not that little reserve there that there might have been before. They know that I’m going to be alright when they speak to me and they know they can say anything to me and talk about things that might have been a bit difficult before.” (P5)*

*“My daughter, I’m probably a bit closer to her now, because I’ve got more time for her...I was talking about the quality of time I have with her, i.e. I could spend time with her and not be snappy and jumpy and want to get up and leave, I can sit down with her and spend time, do things with her.” (P7)*

Box 4.11: ‘Change on both sides: Asserting separateness’: Quotes from patients

*“This is the first time I’m actually putting myself first because in the past I never...I wasn’t worthy to put myself first and secondly, you know, everybody came before me and I’ve now realised that balance definitely has to change because if I’m not well then I’m actually not going to be able to look after my family as I actually want to look after them.” (P1)*

*“In a sort of selfish way I know where I have to go, and you can either join me or...” (P8)*

*“But one thing I know is I can’t go back into the situation that I was in. Because it’ll destroy me. And it’s as simple as that.” (P8)*

*“I’ve obviously kind of done what I need to do to get better in my own way ‘cause they would say kind of ‘help me understand’ and I’d say ‘well I don’t fully understand myself so I can’t help you understand, and it is a family disease and I know you’re affected but you’re going to have to help yourself.’ Because they’d say, you know, ‘you need to support us,’ and I said, ‘I can’t support you, like I’m barely supporting myself, you can’t ask me to emotionally support you and help you understand.’” (P10)*

Box 4.12: 'Change on both sides: Accepting separateness': Quotes from patients

*"He used to sort of enable me to...sort of have my blips because it kept, that gave him control and of course he doesn't have that now. And because I have all the support and because he's realising that actually he's got to be supporting me not tearing me down, it's really changed, the dynamics. And he's found that quite difficult."* (P3)

*"I mean it was really upsetting for her...but she's sort of taken it on board and you know, this sort of allowing the space and allowing me, not forcing me to social things and doing that, there's much more understanding. 'Oh you may not want to do this,' and I say, 'no, not really,' and she says 'fine' and she'll go and do it or whatever. So that's much better. Much better."* (P8)

*"I could probably make a list of things in how both of us have changed. I can see my parents being so much more relaxed and so different to how they were before <Rehabilitation Centre B>, even before they found out that I was drinking too much. Just everything, they're just...they've just completely stepped back in a way."* (P10)

*Hypothesis for a grounded theory.* When viewed globally, the theme which remained relevant across all three phases of the rehabilitation process was distance regulation. While there was a general trend across the sample (as discussed below) and fluctuations in closeness and distance were a given, it cannot be said that there was one consistent pattern of change that held true for all participants and all relationship types. However, life after rehabilitation varied more from family to family than life before or during treatment, phases which contained many common experiences. Besides distance regulation, a secondary theme was the persistence of patients' self-focus across the rehabilitation process. It is interesting to note that for most patients this key driver of interpersonal process did not appear to change during treatment.

Speaking generally, across the rehabilitation process alcohol patients moved from a position of distance from their families to one of closeness during residential treatment, before re-introducing distance again after discharge. During active drinking, nearly all of the alcohol patients interviewed perceived themselves as physically and/or emotionally

isolated from their families. Primarily self-focused, few participants had a clear sense of their impact on their relatives. At the point where drinking escalated and treatment became necessary, distance between family members and alcohol patients decreased dramatically as families overwhelmingly stepped in to facilitate treatment entry. This closeness persisted as families supported their relatives through rehabilitation, even as patients themselves maintained the same self-focus as during their drinking days. After treatment, distance increased again, though for a variety of reasons: some patients simply prioritised their recoveries, others redefined their relationships by asserting their separateness from partners or family members, still others found themselves back in problematic patterns which did not allow for continuing closeness. Self-focus remained patients' predominant orientation.

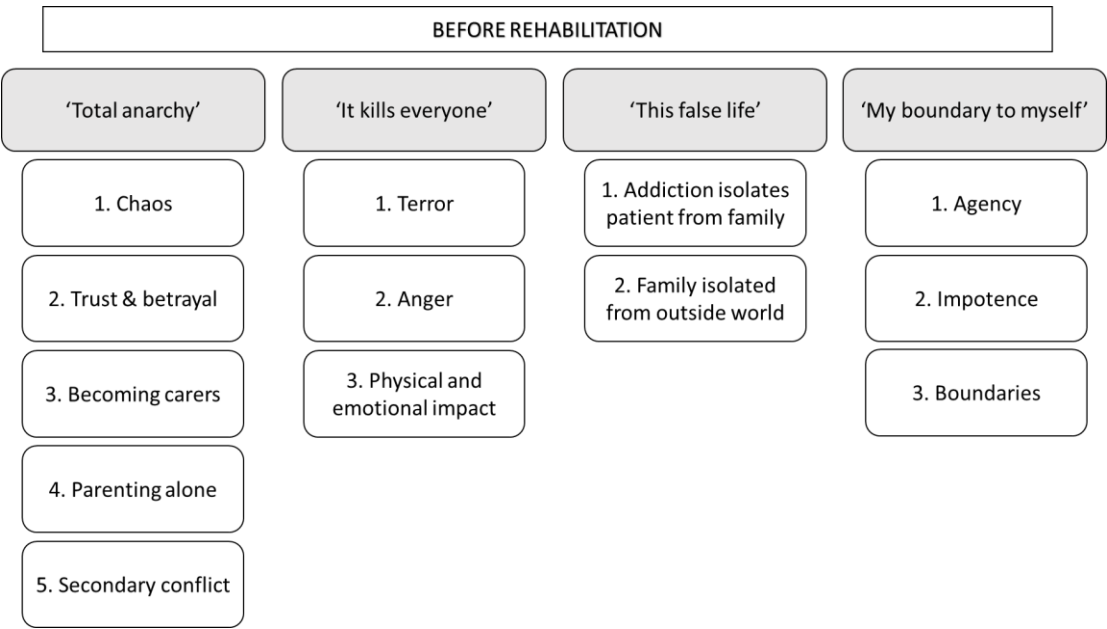
This particular pattern of fluctuating closeness and distance appeared repeatedly across the sample but did not, however, hold true across all relationships. It was more frequently observed in intimate partner relationships or relationships with adult children; in relationships between parents and young children, closeness was more likely to be maintained or even increased post-discharge. Nor was it the primary pattern across all participants: a minority of those interviewed seemed to use the rehabilitation process to detach from relationships they felt trapped in. (Incidentally, in the current sample these were all men.) Ultimately, however, this pattern and its exceptions all provide evidence for family change across the rehabilitation process and grounds for hypothesising that shifts in closeness and distance are a predictable component of this change. More interviews with alcohol patients are required to determine whether there are circumstances in which specific patterns consistently arise.



Results: Family members

Like the sample of alcohol patients, family members interviewed as part of Study 2 were asked to describe life before, during and after rehabilitation to identify common experiences and investigate change across the rehabilitation process. As in the previous section, each phase is presented in diagram format below and then described in detail using direct quotations from participants. At the end of the section, the relationship between the categories in each phase is outlined, providing a hypothesis for a grounded theory of family change from family members’ perspective.

Figure 4.6: Before rehabilitation: Categories describing the family’s experience



*Before rehabilitation.* Four overarching categories emerged from family members’ accounts of life before alcohol rehabilitation, each containing a number of subcategories. Category names are taken from participants’ own accounts. The first category, ‘Total anarchy,’ describes the ways in which family structure was fundamentally altered by alcohol misuse in an environment of distrust and chaos. The second category, titled ‘It kills everyone,’ examines the physical and emotional repercussions of this on

family members. Category three, ‘This false life,’ describes how family boundaries, both internal and external, were determined by the presence of addiction. Finally, category four, ‘My boundary to myself,’ describes family members’ response to the situation, the essential conflict between impotence and agency, and how some families established boundaries as a way of resolving this dilemma.

‘*Total anarchy.*’ The first two subcategories under this heading describe the chaotic environment created by alcohol misuse in the family home, a theme discussed by all of the family members interviewed in Study 2. Participants overwhelmingly described a loss of control over their own lives, a feeling of being pulled along by events. They were exhausted by the lack of predictability and reported feeling miserable and mad. They spoke evocatively of the deterioration of family life into shouting and arguing. Adding to the overall atmosphere of trauma, family members described how their relatives had lied to them and stolen from them, the recurring betrayals making trust difficult. They grappled with self-doubt as their perceptions of reality were challenged by their alcohol dependent relatives.

Box 4.13: ‘Total anarchy: Chaos’: Quotes from family members

*“It causes anarchy in a family, that’s the best way of putting it. And proper trauma. It’s a bit like living in a war zone because the whole dynamic, the balance of the family gets completely thrown to pieces.” (FM1)*

*“I would always know when she was...having one of her moments, or her downs, or that part of what I would call the rollercoaster. And we would be going down the big dipper.” (FM4)*

*“The last four years building up to him going into <Rehabilitation Centre B> was, um, manic. Manic and very stressful. And um, just chaos...It was very like madness. I felt mad.” (FM7)*

*“I couldn’t see out of the whole situation because it was every day. There wasn’t a day of rest when you could think that everything would be alright, you were caught up in this drama.” (FM10)*

*"It was destructive, it was destroying the family, the arguments, the shouting, I mean there was just never a quiet moment, it was just...it was chaos." (FM10)*

Box 4.14: 'Total anarchy: Trust and betrayal': Quotes from family members

*"It's difficult because any relationship is based on trust so on one hand your brain is saying, 'I know she's going to lie, she has to lie,' and on the other side it still hurts each time because you want, you need to believe, to trust in order to keep going." (FM1)*

*"I'd come home and, you know, find him in a state and he'd say he wasn't drinking but I mean it was obvious...you'd just find bottles all over the place." (FM6)*

*"He lied continuously, he lied about everything, to work. Every single day was just a nightmare." (FM10)*

*"I spent two hours going round the house and the garden collecting the bottles that I knew he'd hid in the house and the gardens. I must have collected 45 bottles of vodka and sort of 35 bottles of wine." (FM10)*

The environment of chaos and mistrust described in the first two subcategories forced families to make structural changes in an attempt to cope. Partners and even children found themselves positioned as carers to their alcohol dependent family members, while the parents in the sample assumed renewed responsibility for their adult children. Family members monitored their relatives' alcohol consumption as well as ensuring their basic needs for food and shelter were met. Family members also expanded their roles to compensate for the absence of their impaired relatives, taking over their financial and even professional responsibilities. All ten interviewees described this restructuring.

Of the 4 partners interviewed in the sample who lived with children, three spoke extensively about the stress of parenting alone, which is the theme of the fourth subcategory. There were concerns about keeping themselves healthy, mentally and physically, for the sake of the children, and also a concerted effort to maintain a semblance

of normality in the home. One participant struggled against her partner's attempts to co-parent while misusing alcohol, which undermined her authority.

Box 4.15: 'Total anarchy: Becoming carers': Quotes from family members

*"My eldest daughter was affected very badly from it at the time, she's a very strong personality but she felt she had to take responsibility all the time, especially if I wasn't at home." (FM1)*

*"My dad also was in financial trouble...we had lots and lots of money outstanding in bills. So my mum who had been the accountant and sort of administrator for the company before they got divorced, came in and sort of did all of the accounts with my dad and spent about four days working on it solidly...she did it all having been divorced for six years." (FM5)*

*"So we've had to clear up a lot of the messes from him, you know. He was meant to be making a presentation one day and my dad had to go over." (FM7)*

*"My total existence was around keeping him happy. Making sure he had a roof over his head, that he had food, that he had warmth, basically things he should have been doing for himself." (FM9)*

Box 4.16: 'Total anarchy: Parenting alone': Quotes from family members

*"The fear goes through you and you keep thinking to yourself actually I have got to be healthy because the children haven't got anyone else. So I have got to stay fit." (FM1)*

*"The kids of course they know there's something wrong and they know that Dad's missing, but I have to try and keep that you know, sort of, life's going to be ok girls, we'll be ok...and the minute I was alone in the car I could cry. So it was almost like a switch...I was very good at controlling my emotions and very good at controlling how I functioned." (FM8)*

*"I think that's the thing I found really hard this time, is knowing what's best and carrying the responsibility of what's best for my children." (FM8)*

*"My younger son, I have quite a tricky relationship with him because...I'm the mother who tells him no, he can't sit in front of the television all day, or he can't play Call of Duty at age 10 years old, whereas my husband because he was drunk would let him do all those things." (FM10)*

The final subcategory under the heading ‘Total anarchy’ summarises participants’ experiences of secondary conflict – that is, conflict arising between family members as a result of the situation at home. Half of those interviewed reported secondary conflict in their families. The quotations below show examples of conflict across different family relationships – marital, sibling, parent-child – illustrating the divisive effect that alcohol misuse had across the family system.

Box 4.17: ‘Total anarchy: Secondary conflict’: Quotes from family members

*“You find yourself in situations where things become distorted...I sometimes would find myself blaming one of my children if they did something, when my wife was in active addiction, did something to upset her. I would think, now you have done that, and she might have another drink. There’s this terrible thing where nobody around her is to blame yet blame gets distributed because everyone is so frightened of the effects all the time.”* (FM1)

*“It was sort of tearing my mum and dad apart as well because he was trying to protect his business, and she...her son was her son.”* (FM2)

*“Cause he’s thinking, right, that’s it, I’m not having him working for me anymore and then I would sort of say, ‘oh, give him one more chance’ and so we was rowing and...I would support, try and stick up for him, try and justify all his moods and disappearances.”* (FM3)

*“You know my mum, not realising, was very emotionally manipulative because of the emotional state she was in. You know, she would sort of guilt trip me into spending time with her and doing things for her, she didn’t know she was doing it.”* (FM5)

*“But I think in terms of being the daughter and eldest, I felt I was really in between the two of them all the time. And I’d go home and there’d be a bottle of wine in the fridge, and I’m like, ‘why is there a bottle of wine in the fridge when we’ve banned alcohol?’”* (FM7)

‘It kills everyone.’ The second overarching category describing family process before rehabilitation outlines the variety of impacts that proximity to alcohol misuse and the resulting anarchy has on family members. The first two subcategories, ‘Terror’ and ‘Anger,’ describe common experiences across the sample, while the third subcategory summarises the myriad of other physical and emotional consequences for family members.

The first subcategory, discussed by eight of the ten participants, was the experience of persistent fear or terror. Relatives often catastrophised, frightened of unanswered phone calls and of coming home to disaster. Family members described a constant state of anxiety, of waiting for a tragedy that seemed inevitable. The other common response, mentioned by 7 participants, was anger. Family members were aware of feeling anger and even hatred toward their relatives during active addiction, but often had trouble reconciling this with the love and loyalty they also felt. They also worried that their anger might exacerbate the drinking.

Box 4.18: ‘It kills everyone: Terror’: Quotes from family members

*“So you live in a, and indeed my children did in different ways, live in a 24 hour zone of fear and terror that you’re going to come home and she is going to be in bed or done something stupid or fallen downstairs or done some harm to herself. There is a kind of literal fear she might be dead.” (FM1)*

*“There were times I would turn up to the house and you’d wonder if you were turning up to a corpse or not, you know, and there were times when I really did think that this was it.” (FM5)*

*“I knew two years before he went into rehab that he needed rehab, and everyone just kept on saying he’s not bad enough, he’s not bad enough...waiting for him to have a car crash then, or waiting for something, waiting for him to die. That’s how it felt.” (FM7)*

*“I think when S is drinking and missing, I’m waiting for the phone call. You know, I think I visualise so many times a policeman standing on my doorstep...just saying I’m sorry but your husband’s dead, we found a body.” (FM8)*

Box 4.19: ‘It kills everyone: Anger’: Quotes from family members

*“It is a difficult process to go through because one understands the nature of it and supports it as much as I can understand it having not gone through it myself, but at the same time you can’t help feeling anger towards the person.” (FM1)*

*“It was in that moment that I realised that actually this man had no control over what he was doing and even though he was putting his own life and his children’s life in danger, he just was physically incapable of not drinking. And I was furious with him.” (FM5)*

*“There’s the unconditional love of being his daughter but also matching that is a real, there was like a, almost like a hatred, you know, anger.” (FM7)*

*“And my youngest hated him. Hated him. Couldn’t even say his name.” (FM8)*

Besides terror and anger, family members exposed to active addiction experienced a range of other physical and emotional consequences which are represented by the third subcategory. Nine of the ten interviewees described how they, their children or other family members suffered as a result of their proximity to alcohol misuse. (The only participant who did not discuss the impact on himself or his children was FM4, who referred to his Edwardian upbringing and tendency to “just get on with it.”) Family members reported physical illness, both emotional upheaval and emotional withdrawal, anhedonia and loss of confidence.

Box 4.20: ‘It kills everyone: Physical and emotional impact’: Quotes from family members

*“It’s not like getting cancer or diabetes, because that’s sympathetic, and in one sense, although it upsets members of the family, it doesn’t actively destroy other members of the family. Unfortunately, this is a disease which not only kills the victim of it but it kills everyone around it as well.” (FM1)*

*“My eldest daughter was affected very badly from it at the time...it was a terrible strain to put on her while she’s studying for GCSEs. The middle daughter, who is 10, started to develop anxiety symptoms of not wanting to go to school, feeling faint.” (FM1)*

*“The fact is that you just turn off, you just switch off, you know and I’ve found that that’s flowed over into other parts of my life.” (FM5)*

*“It affected my confidence, it affected my relationships with my friends...” (FM7)*

*“I physically couldn’t drink and eat, that’s a physical effect it has on me. Cause I just had this awful, awful churning, and I like my food, um, and I don’t think I even drunk, I couldn’t physically swallow water...I thought, I’m going to go under here. Not physically cause of the eating and drinking, but mentally I could feel myself really struggling to function and to exist.” (FM8)*

*“My fifteen year old shut herself off and wouldn’t talk. I don’t want to talk about it, I*

*don't want to talk about it.' C, my eldest...every time we got in the car, 'Mum, listen to this song'...she was looking for really emotional songs to play and cry."* (FM8)

*"I mean it made me physically ill, so I did have quite a few times I was being treated for irritable bowel, and I feel that was part and parcel of the problems I was having with A."* (FM9)

*'This false life.'* The third category describing family process before rehabilitation is concerned with the management of both internal and external boundaries. The overarching theme is one of isolation. Within the family, eight of ten interviewees reported that their relative withdrew as their dependence on alcohol grew, isolating themselves and disengaging from family life. At the same time, nine of the ten participants described how the experience of living with alcohol misuse increasingly isolated the family as a whole from their wider communities and support networks.

In terms of isolation internal to the family system, family members reported feeling abandoned both practically and emotionally by their relatives during active drinking. They described how their relatives slept all of the time, missed family social events and celebrations, and made excuses to avoid them. Several family members referred to physical signs of disengagement, especially their relatives' eyes, which they described variously as black, blank, sunken, glassed over, milky, watery, and not focused. In some families, the sense of internal isolation was compounded as relatives avoided each other to avoid discussing the reality of the situation.

The family's isolation from the outside world as a result of alcohol misuse at home covers a wide variety of experiences. Families described how they kept their situation a secret, either because they did not want to share this reality with others or because their alcohol dependent relative asked them to keep it quiet. Families were further isolated by their often mentioned feeling that no one outside the situation could understand it or help



them. They described feeling failed even by medical and psychological professionals, who lacked a solid understanding of addiction.

Box 4.21: ‘This false life: Addiction isolates patient’: Quotes from family members

*“Unfortunately it is a very, very solipsistic disease, so that the person that is suffering from it blocks everyone else out. It’s very, very selfish. The only relationship you have is with drink and nothing else. And so obviously my children had to cope with the fact of being blanked out and getting used to her being in bed all the time.” (FM1)*

*“He’d just come and sleep with his hood up, wouldn’t play with his niece and nephews and they always know him as fun Uncle E and he would sort of shun them to the side. Just come and sleep in the front room with his hood up, hide away, wouldn’t come to big family events...complete change, just sort of a shell.” (FM2)*

*“They both know, they both see the eye – we call it at home ‘the eye’ – and that something has changed, there has been that adjustment from that loving, all-caring, attentive mother to someone who’s then...in a different dimension.” (FM4)*

*“When he goes on one of his binges, you know, he disappears from...well, he’s unconscious basically...I mean, you know, S was drunk, very drunk, he was unconscious on the sofa downstairs...the day I gave birth to my third child.” (FM8)*

Box 4.22: ‘This false life: Family isolated’: Quotes from family members

*“I suppose I was quite isolated, it does make you isolated in it. And there is only so much people not living in the house can take, not everybody fully understands it. You can only really understand it when you are on the frontline I think.” (FM1)*

*“M didn’t want anyone to know so it was a bit clandestine this whole thing, you know. Six weeks away, from her point of view she wanted people to feel, oh, she had gone to South Africa or gone on holiday somewhere or not into rehab, because of the stigma of it....So I didn’t tell everyone.” (FM4)*

*“There’s nothing that they can do and I think that’s the helplessness and hopelessness of the addiction, is nobody can help you. No one...I think the only way to get through it is independently. Cause you actually burden people...I’m not ashamed to say my dad’s an alcoholic, it’s just what that then does to the other person...I don’t think you can understand it unless you have one in your family.” (FM7)*

*“I was very, very good and still am very good at putting on the playground smile...some days there was horrendous stuff going on at home, but I’d still, the day after my husband attempted his life in which I’d had helicopters and police dogs, and by the next morning I*

*was there with the playground smile on.” (FM8)*

*“They’ve always found it very difficult though, particularly my eldest. They get very cross and very frustrated because the people who aren’t in the world of addiction, gosh, they’re trying their best and they’re great, they’ve been a great support, but they say things that make my children annoyed, so they don’t really go to anybody at school... You know I think you can’t explain to people who aren’t living in it quite what it’s like.” (FM8)*

*‘My boundary to myself.’* The final category describing life before rehabilitation concerns the family’s conflict between resignation and action in the face of alcohol misuse. Family members described the many ways they tried to reduce relatives’ drinking or push them toward treatment entry. They described monitoring or controlling patients’ consumption, removing them from risky environments, calling AA or medical professionals on their behalf, and even begging and pleading with them.

In the end, family members were integral in facilitating treatment entry, but there were many failed attempts before this point was reached. Family members remembered with frustration the months or years in which they were unable to make the impact they desired, which left them feeling impotent. They often found this position of impotence reinforced by medical professionals and 12-step programmes (e.g. Al-Anon), which encouraged them to accept it. Doing so, however, was a constant struggle during which family members experienced the terror and physical and emotional repercussions described in category two above. To counteract this, families responded by asserting their agency the only way they could: by establishing boundaries around the alcohol use and the alcohol dependent relative.

The boundaries enforced by family members took different forms. In some families, serious ultimatums were given: if relatives continued to drink, they were told they would be ostracised from the family group or cut off by children or partners. In other

families, the level of consumption itself was associated with specific consequences (e.g. not being allowed into the family home when drinking). Finally, family members attempted to establish tighter boundaries around themselves as individuals, separating themselves from their alcohol dependent relatives both physically and emotionally.

Box 4.23: ‘My boundary to myself: Agency’: Quotes from family members

*“I was in this surreal situation where I bought a bottle of vodka and kept it in the fridge so that she could drink it and me monitoring it.” (FM1)*

*“My brother calls me and says, ‘J, I think Dad’s got a glass of wine.’ And I’m like, ‘smell it,’ and P smelled it and says, ‘smells like wine.’ So then I was like, ‘taste it.’ ‘Right, it definitely is wine.’ I was like, ‘throw it away, put the kettle on, make him a cup of coffee, hit him and put me on the phone’ and I had such a go at him.” (FM5)*

*“Since he’s been in rehab the first time I’ve sort of rescued him again and again. I mean he would be well dead by now if it wasn’t for me, that’s absolutely true.” (FM6)*

*“I wanted something to happen where he reached his rock bottom... ‘cause I knew he wasn’t going to get better ‘til he found his rock bottom. So I was trying to almost have that, helping that to happen.” (FM7)*

*“I was like a detective in the house, you know, always looking, always searching, trying to smell his breath.” (FM7)*

Box 4.24: ‘My boundary to myself: Impotence’: Quotes from family members

*“I’d been to our doctor and said ‘can we do something?’ And the doctor said, ‘no, you can’t. It needs to be her doing something rather than you wanting something to be done.’ So there were several wasted years in that respect where I said I had a concern and it was stressful for me yet I couldn’t do anything about it.” (FM4)*

*“I just had that knowledge from Al-Anon that you have to let him find his rock bottom...there’s nothing we can do. But I don’t know, I still don’t know, how you’re supposed to live in any kind of calmness waiting for somebody else to hit rock bottom. Because all the guidance in the literature from, you know, Courage to Change, is about living in serenity and I don’t know how you’re supposed to do that while somebody is literally on self-destruct.” (FM7)*

*“And it would just go on every single day. Every day you’d think that you could make it better and every day it just got worse.” (FM10)*

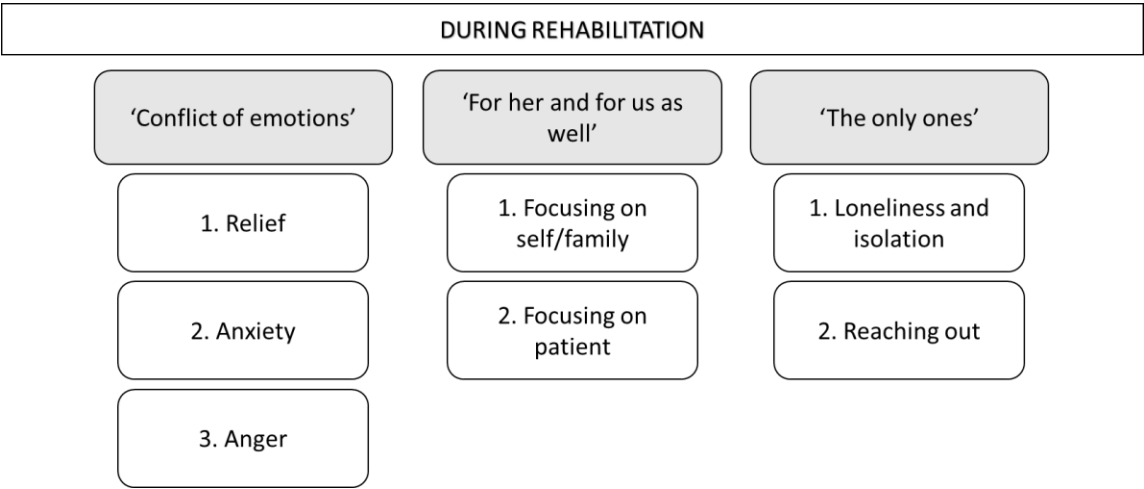
Box 4.25: ‘My boundary to myself: Boundaries’: Quotes from family members

*“Both his brothers come round and said, ‘you walk out this door tonight, don’t bother coming back. I don’t care, you are not putting Mum and Dad and everyone else through that again. You go, you go and have your binge but find somewhere else the next morning because as a family we’ve had enough.’” (FM2)*

*“You know I said to him I wouldn’t see him unless he went to rehab...P had said to him about a month before that that he wouldn’t see him unless he was sober, ever, and I said to him I will not come round and I will not answer the phone to you and I will not speak to you until you are sober.” (FM5)*

*“When the girls were little and he came back paralytic, not able to walk and all the rest of it, and, you know, my boundary to myself had been he can’t come in the house...And you know, he was trying to get in the house. And I physically had to, you know, we were fighting with the door. And I’d managed to get it locked and I just knew, I was so, so determined, it wasn’t about him, it was about me, I was so determined, I had to stick to my word. ‘Cause I think I probably felt, this is all I have left.” (FM8)*

Figure 4.7: During rehabilitation: Categories describing the family’s experience



*During rehabilitation.* Three overarching categories and several subcategories emerged from relatives’ accounts of family life during alcohol rehabilitation. The first category, ‘Conflict of emotions,’ describes the complex response family members had to the absence of their alcohol dependent relatives. The second category, ‘For her and for us as well,’ looks at how family members sought a balance between supporting patients and

focusing on themselves during the separation. Finally, the last category, ‘The only ones,’ describes how families at first maintained and then finally reached out from a position of isolation to reconnect with the outside world.

*‘Conflict of emotions.’* In the vacuum created by residential rehabilitation, there was space for a myriad of emotions to emerge in family members. The initial and most commonly expressed feeling, however, was relief. Family members were grateful to know that their relatives were being taken care of, that they were safe in the hands of professionals. Relieved of their own caring responsibilities and free from the terror that had accompanied destructive drinking, they felt able to resume their own lives. The majority of family members interviewed looked back with fondness on the peace, and even bliss, they experienced during this period.

This relief was not absolute, however. Family members described how rehabilitation brought a conflict of emotions, the release from responsibility accompanied by anxiety and anger. Anxiety was twofold: family members worried about whether and how well patients were engaging with the treatment, but were also concerned about the future and the sustainability of the change. Anger was directed at patients not only for the suffering they’d caused, but also for leaving family members with a mess to clean up in their absence.

Box 4.26: ‘Conflict of emotions: Relief’: Quotes from family members

*“I think the immediate feeling was one of relief from the trauma...just to know that she was safe and that it wasn’t our responsibility to look after that, that someone else was looking after it...with varying degrees of professional expertise was a great relief.” (FM1)*

*“Bliss. Absolute bliss. ‘Cause he was safe. The feeling that he was in a safe place and that we could have a rest.” (FM7)*

*“It was a release. ‘Cause he was away. And we could just get on with our lives. And particularly because he’d been so, you know, so extreme, by the time it had got to the point*

*where he was going to rehab, I was desperate just to get rid of him, you know. So it was a relief for all of us, where we didn't have to worry, where, what, when, how, why, and all that sort of side of it.” (FM8)*

*“I must admit life was very peaceful. Because he wasn't in a position to bother me. I don't know whether that's the right word to use. When he was in a position where he couldn't get to me, he had everything he needed, then I didn't have a problem.” (FM9)*

Box 4.27: ‘Conflict of emotions: Anxiety and anger’: Quotes from family members

*“I felt my anger most intensely when my wife was in rehab, because I had time to feel angry.” (FM1)*

*“I think the first couple of days when he was away it was really scary ‘cause he wasn't allowed to call or make any contact...I'm sure if there was a serious problem they would have contacted us but it was the not knowing. ‘Cause he's still like, they're still your babies no matter how old they are, aren't they?” (FM3)*

*“So you're battling between this ‘thank goodness’ and also this sort of, I suppose anger really, that he's left me yet again with three children, all these worries, and you know, financial and jobs and this mess he's created.” (FM8)*

*‘For her and for us as well.’* While patients were in their rehabilitation programmes, family members had more space to focus on themselves, and largely took advantage of the opportunity to do so. Most did this alongside a supportive focus on their relatives in treatment. For some families, however, the patient was still the primary focus of family life, even in his or her absence.

Most families – eight of the ten interviewed – recognised that they needed to make self-care a priority during the rehabilitation period. Families spent quality time together, focused on personal projects and the children, and distracted themselves with visits to friends. They used the release from tension to begin to recover physically and emotionally from what for most had been a long and painful ordeal. A few family members acknowledged their own need for treatment at this point and engaged with Al-Anon.

Two of the family members interviewed took this self-focus further and limited contact with patients whilst they were in treatment. The rest, however, continued to support their relatives through frequent phone calls and visits, engaging in family groups and even family therapy where these were offered. Some struggled to find the right balance between supporting patients and having space for themselves, as the structured treatment environment meant that contact with patients was largely on their terms.

A minority of the interviewees (n=2, from the same family) described how family life continued to revolve around the patient in his absence. For this family, though the rehabilitation experience brought them closer together as a group, the time spent apart was used to plan for the patient's return, to prepare the home environment to support abstinence, and to understand why he had turned to drink in the first place.

Box 4.28: 'For her and for us as well:' Quotes from family members

*"That period was kind of necessary both for her and for us as well just in terms of recovering physically, as well as emotionally." (FM1)*

*"During the six weeks that she was away, I drove two and half thousand miles, driving there, home, picking up the boys, seeing them, watching them play matches, whatever it may be just to make sure that we were all together." (FM4)*

*"That's when I went back to Al-Anon, started sort of reaching out and taking responsibility for myself and letting go of S." (FM8)*

*"He phoned me 6-8 times a day and eventually I phoned up <Rehabilitation Centre B> and said you've got to stop him phoning me because I was just like in such a mess anyway and I was just about protecting my children big time...and at that point I did seriously go and get some help and go to Al-Anon again because I felt that I needed help a lot." (FM10)*

*'The only ones.'* For some families, the boundaries they had maintained between themselves and the outside world began to shift during treatment. At first, the absence of the alcohol dependent relative increased the isolation that families already felt: having a

relative in residential rehabilitation alienated them still further from the day-to-day lives of those around them, who could not understand their experience. It was also during this time, however, that families began to reach outside of themselves for help and support. As mentioned in the previous section, several family members engaged with Al-Anon at this point. Still others opened up to friends and relatives about the situation at home. Sometimes this was unintentional, as the conspicuous absence of the patient provoked questions.

Box 4.29: ‘The only ones: Loneliness’: Quotes from family members

*“It just feels a big wrench and it feels that you are the only ones, the only ones doing it and why, why you, why are you having to go through all this?” (FM4)*

*“When he’s in rehab I felt isolated, because there’s no one...I wasn’t back in Al Anon then, so you feel very alone. And there’s a limit to how much you can talk to friends, and you’re living this false life, like I say the playground smile, so you’re living this false life, so you stop going out, because you don’t want to go out and pretend.” (FM8)*

*“And it was a very lonely experience because I was very by myself for the month that he was in there. I was by myself, I wasn’t wanting to be with too many people, I did a lot of crying, it was a very miserable, miserable time.” (FM10)*

Box 4.30: ‘The only ones: Reaching out’: Quotes from family members

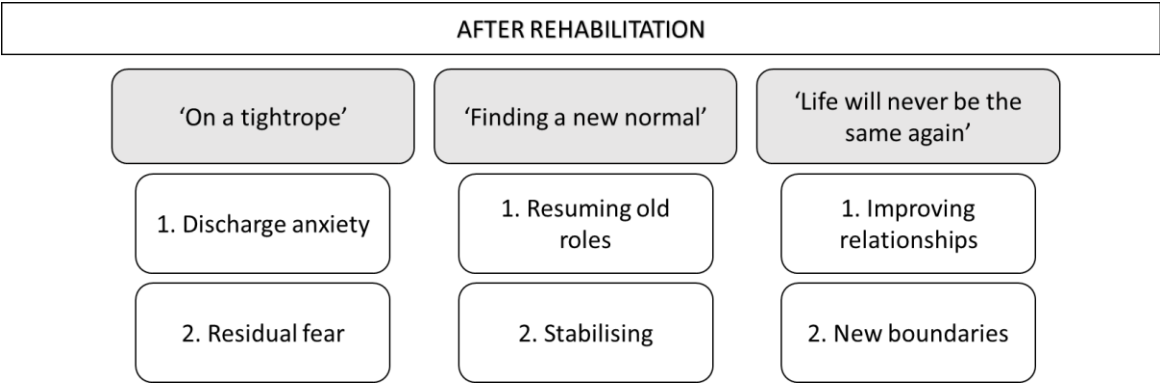
*“Inevitably people would ask after M and I would then have to explain what was going on.” (FM4)*

*“I did get to a point where I did start talking to my sister about it. And she said to me, ‘I wondered when you were going to start talking to me, I know what’s going on. I thought I’ll just leave you and when you’re ready you’ll talk to me.’” (FM9)*

*“The first time he went to <Rehabilitation Centre B> he didn’t want me to tell anybody...When he came out he found that a few people had found out and he was furious with me. Then the second time he went back in again, I took the decision to write an email to twenty of our friends and family.” (FM10)*



Figure 4.8: After rehabilitation: Categories describing the family’s experience



*After rehabilitation.* Three overarching categories and several subcategories emerged from relatives’ accounts of family life after alcohol rehabilitation. The first category, ‘On a tightrope,’ describes the continuing anxiety families experienced from discharge into early recovery. Category two, ‘Finding a new normal,’ illustrates how some families stabilised and resumed the status quo after rehabilitation, while category three, ‘Life will never be the same again,’ explores the changes family members perceived in their relationships as patients reintegrated back into life at home.

*‘On a tightrope.’* Fear continued to be a theme in the period after rehabilitation, with seven of the ten interviewees still experiencing considerable anxiety even as relatives’ time in recovery increased. At the point of discharge, family members juggled hope and uneasiness as they considered the possibility that the chaos of life before rehabilitation might resume. They worried about triggering relapse in vulnerable patients, and grappled with questions about how to behave around relatives and whether or not to discuss the new reality. A few participants complained about the lack of guidance from treatment providers at this juncture.

Once patients were home again and day-to-day life resumed, interviewees spoke of the residual fear that continued to colour their interactions with their relatives. Family members admitted to reacting to the past in the present – unanswered phone calls, for

example, were a trigger to anxiety for many participants, who associated them with relatives disappearing during active drinking. They continued to worry about relapse and were alert to stressful situations that might trigger it; they also wondered about their own contribution and often moderated their drinking as a cautionary measure.

Box 4.31: ‘On a tightrope: Discharge anxiety’: Quotes from family members

*“But of course when it came to her being released everyone was fearful again. You know, on one hand you think this is a chance, this is hope but of course this fear that a relapse would happen again and you’d be back in the trauma that you’ve escaped from for six weeks.” (FM1)*

*“It was sort of a fear factor – oh my god, he’s going to come home, is it going to be alright? Should we talk to him about things or should we not talk to him? Does he approach us or do we approach him?” (FM2)*

*“What should you expect or what help can I give? Should I not go to the pub with her or to big parties or assume that she’ll be fine, you know, whatever it may be, there is no sort of guidance one way or the other...Should you try and surround yourself as normal as possible with people or should you talk, you know, I’ve had no guidance on any of that.” (FM4)*

Box 4.32: ‘On a tightrope: Residual fear’: Quotes from family members

*“I still occasionally get twinges of panic if she doesn’t answer the phone, and of course, one has, what’s the word... sense memories jerked by things. So, you know, she might say, ‘there were a lot of idiots at AA, I am really bored with it, I got really bored with it today.’ That will still make me fear that, oh my god, she’s lost faith in it and she’s going to stop going and I mean, which isn’t, wasn’t the case, it was just her having the right to say that there were a lot of boring people there today. But of course it makes you fearful when you have been on the end because very often in the past when she’s relapsed, I had heard exactly the same thing. Now it’s a different context but I’m still hearing what happened in the past.” (FM1)*

*“My eldest took a little while longer to adjust to that, because she still, you know, sometimes if I phone her from school about something innocent, like, can you buy bread on the way home, she will still say, ‘are you okay, what’s the matter?’ when she first picks up the phone, which I completely understand and identify with.” (FM1)*

*“It hasn’t been plain sailing, there’s always been a level of stress...I haven’t really relaxed around it...I just didn’t want to trigger, push her into an area that it would be my fault if*

*there was a trigger to relapse so I've, I think, been very conscious of that and tried to make that transition as easy as possible. I try not to drink at home...whereas, you know, most days I would probably have a glass of something when I got home, now I don't.*" (FM4)

*"Well, his gallery just rang up to say they are closing down, the guy is retiring so I thought, 'oh, I hope that doesn't make him have a drink.' That's very worrying."* (FM6)

*"And yesterday...I panicked 'cause I couldn't get ahold of him, missed calls, texts, he was golfing, but um, I went into that place of 'Mum, I can't get ahold of him' and she said 'he'll be fine, he will be.' But I was like, I just went into this sort of whirl..."* (FM7)

*"I would say they're all back to a normal relationship, but the fear will always be there, you know. Let's say S didn't answer his phone to C because he was in a meeting today, I know that the triggers are very, very close to the surface of how she'd react, but I think I'd probably say the same about myself, you know."* (FM8)

*'Finding a new normal.'* For some families, life after rehabilitation meant a return to what they considered normal family life. These families stabilised as patients stepped back into their old roles, with parents resuming their customary authority and partners re-engaging with one another. This happened quickly in some families and very slowly in others, and often different relationships recovered at different speeds. The tone, however, was largely positive: in only two instances was the return to the status quo described as a negative event, and one of these was in a situation of relapse.

Box 4.33: 'Finding a new normal': Quotes from family members

*"The children are very much using my wife as the authority figure in the family and referring to her if they've cut their knee or, you know, when she wasn't well, obviously they were coming to me...It feels as though things have got back to a stability."* (FM1)

*"Our daughter has just had her eleventh birthday this week and M actually used it as a way of, not payback exactly, but giving her daughter a good birthday for the first time in three years."* (FM1)

*"My other brother works with him now, so sort of getting into the routine of E going back out to work, not just being here. Not having our guard up 24/7, questioning 24/7...So yeah, probably about a week, between a week and two weeks and then it sort of felt, it just felt normal again."* (FM2)

*“I don’t feel like I am living with an alcoholic.” (FM4)*

*“No, I didn’t really change anything much. I mean, maybe I should have but I didn’t.” (FM6)*

*“So it was all very strange, it was like having a stranger in the house ‘cause he’d done, you know, a good couple of months in rehab on and off...and obviously as well on top of that the fact that he’d been working abroad, we’d become self-sufficient really...it’s taken up ‘til now, so really a year since he relapsed, and my 12 year old, she’s allowing him now to give her a hug.” (FM8)*

*‘Life will never be the same again.’* In contrast to the category above, for some families, the experience of residential rehabilitation provoked changes in their relationships that carried over into life after discharge. Seven of the ten family members interviewed reported improvements in at least one aspect of family functioning during the period after rehabilitation. Participants described less conflict, more shared time together, and in some cases, increased warmth in their relationships. Improved communication was appreciated by family members who were used to disappearances and unanswered phone calls. One of the most frequently reported improvements, however, was patients taking more responsibility for themselves, which freed relatives to focus on themselves as well.

As patients actively prioritised their own recoveries, new boundaries were established and a measure of balance restored to family life. Participants spoke of pursuing individual goals, of finally achieving some independence from patients. For most this separation was positive, and interviewees reported lower stress levels and even happiness as they focused on self-development. For one participant, however, this distance was a rupture, and left the future of the relationship uncertain.

Box 4.34: 'Life will never be the same: Improving relationships': Quotes from family members

*"Before he'd never say I love you to my Dad but now he sort of says it all the time. And if they're having a heart to heart, he'll say it and hug him which is quite nice for us to see as well." (FM2)*

*"Whereas before we'd sort of say, 'oh, they don't need to know that,' whereas now we will tell each other which is quite good." (FM2)*

*"It sounds awful because it does sound like I'm controlling but it's not done in a controlling way...He knows that I need to know that he's arrived at an AA meeting. He always texts 'here, by the way,' you know, and, 'that's great, have a good meeting'...so our communication I would say has increased." (FM8)*

*"I think the drinking took away the conversation. And he was never a big conversationalist, but I think that the drinking, you know, the conversation went. All I did was shouted & screamed. Now there's no shouting and there's no screaming and it's all very calm." (P10)*

Box 4.35: 'Life will never be the same: New boundaries': Quotes from family members

*"I'm going to the gym and all this sort of stuff and I've lost loads of weight myself. I spent so much energy putting it into other people that now actually I'm spending some time on myself." (FM5)*

*"I learned that when you stop listening to your instincts, you stop listening to yourself and that's when you lose your confidence. I definitely, that happened while Dad was ill...and now yeah, just to have the strength to listen to them and to honour that...equals confidence and self-worth. So little steps, you know. But I'm getting there." (FM7)*

*"And that's what I think has been the biggest change this time, I've just completely let go. I don't know whether I've let go because he's taken responsibility, if he wasn't taking responsibility, I don't know whether I would have let go, if that makes sense...I'm taking responsibility for myself, you know, I go to Al-Anon and I do what's necessary for me. And vice versa, you know, and I don't interfere..." (FM8)*

*"It's calmer. It's quieter. We don't see so many people. I do, by myself, but he doesn't... We lead very quite separate lives. We lead quite quiet lives. He does what he wants to do. There's no question about asking what I want to do, he does what he wants to do." (FM10)*

*Hypothesis for a grounded theory.* There were three main themes which emerged across all three phases of the rehabilitation process for family members. Firstly, a gradual shift can be observed from a dominant other-focus before rehabilitation to a growing self-focus post-discharge. Alongside this, there was a parallel opening of the system to outside influence across the same period. Finally, despite increased time in recovery, the fear and anxiety that family members felt did not attenuate across the process.

For family members, life before alcohol rehabilitation was entirely governed by the ups and downs of active drinking. This meant that family members primarily operated from an other-focus, concerned either about their alcohol dependent relative or about limiting the impact of alcohol misuse on other family members, especially children. Self-focus was not possible until relatives were removed from the home and safely contained in the treatment setting. Even at this point, it was tentative, balanced with other-focused preoccupation with and support for patients. Once relatives returned home, in those cases where stability was re-established in an environment of recovery, a heightened self-focus became possible, accompanied by the pursuit of independent goals. In the two instances where there was relational rupture or relapse, both participants assumed a self-focus for self-preservation, though a return to a preoccupied other-focus might equally have been expected.

Parallel to the change in focus, the boundary between families and the outside world shifted across the rehabilitation process. Family members, who had been so isolated from their wider networks and communities during active drinking, began to slowly reach out to others while patients were in treatment. This continued into recovery, helped along by their growing ability to maintain a self-focus. At the same time, however, the distance that family members perceived in their relationships with patients did not seem to change

significantly, even as aspects of family functioning improved. Relationships characterised by physical and emotional distance before rehabilitation were still characterised by separateness afterwards, though the latter was perhaps of a healthier sort. Family members rarely reported increasing closeness across treatment (n=2).

The changes in focus and systemic regulation of distance across the rehabilitation process support the idea that families change during residential rehabilitation, and allow us to hypothesise a possible mechanism and direction for this change. As with the patient sample, however, while these patterns appeared frequently, they were not observed for all participants or all relationships, and more interviews are needed to understand the limits of applicability.

Finally, throughout all the stages of their experience, the fear and anxiety family members carried with them remained. Even as they took steps toward personal and relational health in a context of recovery, like trauma survivors, they often responded instinctively to the past. A lingering consequence of long-term exposure to alcohol misuse, it may be as important to family recovery to understand this crucial way in which families did *not* change as it is to understand the ways in which they did.

## Chapter Five: Discussion and conclusion

This thesis has focused on alcohol dependent patients and their families, and aimed to understand (1) whether the state of family relationships at treatment entry was associated with patient outcome and (2) whether changes occurred in family relationships across the rehabilitation process. In this final chapter, the key results from each study will be presented and discussed, and the ways in which the studies' findings inform one another will be considered. This will be followed by a discussion of the broader implications of the research programme as a whole. The limitations of the methodology will then be addressed and avenues for future research suggested before concluding.

### Study 1: Summary and discussion

Study 1 set out to investigate the aims described above using a longitudinal prospective cohort study, allowing both predictors of outcome and family change to be observed in real time. Drawing on systemic ideas from both research and theory (described in the first two chapters of this thesis), the initial hypotheses guiding the design of the study emphasised the relevance of family relationships to the rehabilitation process. Healthy family relationships at baseline (defined by higher levels of flexibility, cohesion, communication and satisfaction and lower levels of conflict, disengagement, enmeshment, rigidity and chaos) were expected to predict better treatment outcomes. Participants were expected to report changes in family process across the transition to and from residential rehabilitation as families responded to the removal of alcohol and the alcohol dependent member. Improvement in family functioning was defined as a movement toward healthy cohesion and flexibility (i.e. away from the extremes of disengagement/enmeshment and chaos/rigidity), better communication and more satisfaction with family life. Movement in the opposite direction on any of these variables was to be considered deterioration.



At baseline, alcohol patients largely reported family functioning in the normative to healthy range. As a cohort, their disengagement, enmeshment, rigidity and chaos scores were well below the normative mean on average, while their flexibility and cohesion scores were at or above this mean. Their cohesion ratio scores in particular were striking – this sample of alcohol inpatients reported 2.5 times as much positive cohesive behaviour as disengagement or enmeshment in their family relationships at intake. As a group, their communication ratings were also slightly above the normative mean. These figures suggest that the families in the sample were functioning better than would be expected given the evidence in the literature for systemic disruption during active drinking. An alternative explanation, however, is that patients did not reliably perceive the disruption to their family lives, at least not in terms of their families' flexibility, cohesion and communication (their conflict scores did not differ significantly from a distressed sample). Perhaps these figures are also due in part to participants' interpretation of the measures used: when completing the questionnaires, patients often reported rating family life as if they were separate from it (please see the limitations section below for a full explanation of this point). This could explain why they felt their families to be functioning well overall but still rated themselves nearly 20 percentile points below the normative mean in terms of their satisfaction with family life.

Organising the sample by polydrug use and attachment avoidance resulted in different patterns of baseline family functioning in two subgroups: polydrug users (n=35) and those reporting high attachment avoidance (n=18). There was no relationship between these two groups (i.e. polydrug users were not more likely to score high on attachment avoidance), but both fell below the normative mean in their ratings of family communication and flexibility where the sample as a whole did not. They also reported

less positive cohesion than their comparison groups (i.e. alcohol users and low attachment avoidant participants respectively). Polydrug users, however, rated their families as significantly more enmeshed compared to alcohol users, while high attachment avoidant participants perceived their families as significantly more disengaged and chaotic compared to low attachment avoidant participants. Though cohesion, disengagement and chaos scores were in the normal range, it is interesting to note the different patterns of distance regulation reported by the two subgroups. The fact that they still largely report normative to healthy functioning despite extremely low family satisfaction, not only relative to their comparison groups but to the sample as a whole, leads to further questions about their perceptions of disruption to family life.

When it came to predicting treatment outcome based on family functioning at intake, only one of the variables tested was able to distinguish between those who completed treatment and those who dropped out: patients' satisfaction with family life. The result, however, was in the opposite of the hypothesised direction: treatment drop-outs reported significantly more satisfaction with family life at intake than treatment completers. In a logistic regression model, higher levels of family satisfaction continued to predict treatment drop-out even when accounting for other known predictors of outcome (e.g. psychological distress and alcohol consumption). The size of the effect was not inconsequential: a 3.5-4% decrease in the likelihood of treatment completion for each percentile increase in satisfaction at intake implies that a patient who scores five percentile points higher on satisfaction may be up to 18% more likely to drop out of treatment. The very narrow confidence intervals associated with this effect – 95% CI [.939, .991] – suggest that it is highly predictable.

There are several possible explanations for this result. Perhaps those patients who feel more satisfied with family life terminate treatment early to get back to their families. Informal discussions with patients contemplating the detoxification-to-rehabilitation pathway support the idea that prolonged separation from family may be a deterrent to enrolling in residential programmes. In the current sample, however, the majority of treatment drop-outs were not early terminations but relapses, suggesting that this hypothesis may be relevant only to a subset of participants.

Another explanation for the result is that a satisfying family life functions for patients like a safety net, making it less likely that they will confront the many challenges they face during the treatment process. They may expect that they will be welcomed back whether or not treatment is successful, perhaps having had experiences of being relieved by family members in the past, and this may impact their motivation to persevere. Conversely, those patients who do not feel they have a satisfying family life to fall back on may be more likely to commit themselves to treatment.

Finally, if the normative to healthy family functioning ratings given by participants at baseline were indeed due to their not having perceived disruption in their family lives, it is possible that those who report high levels of family satisfaction have a particularly inaccurate view of their relationships. Perhaps it is these distorted perceptions that are relevant to treatment completion: this group may underestimate their own need for treatment, or the rehabilitation process may eventually challenge their views to an intolerable degree. There is evidence that recognition of deterioration in family life drives professional help seeking among alcohol patients (Orford, Kerr, et al., 2006), so those who perceive their family lives as highly satisfying will in any case lose a powerful incentive to pursue treatment.

None of the other family functioning variables were able to distinguish between treatment completers and drop-outs statistically, but it is interesting to note that all but one of the mean differences between these groups were in the opposite of the hypothesised direction. Treatment drop-outs reported healthier family functioning on every measure except the rigidity subscale. That this pattern appeared globally raises the question of whether the predictive relationship between higher family satisfaction and increased treatment drop-out is part of a broader effect that merits further attention. Reporting healthier family functioning at intake – whether a distortion of reality or not – may be a potentially important early indicator of treatment failure.

The final result relevant to the question of whether family relationships at intake were predictive of patients' response to treatment came from an exploratory investigation of patient attachment in a subsample of study participants (n=41). This subsample, which included only those patients currently in relationships, scored higher on attachment avoidance than a normative sample. Furthermore, those reporting the most avoidant attachment behaviour rated their family functioning as significantly worse across all but one of the variables tested, and their ratings of family satisfaction were in the 17th percentile of the population norm, the lowest result for any group in the study. In a logistic regression model that also included alcohol consumption, family satisfaction and psychological distress, higher levels of attachment avoidance in patients' primary romantic relationships successfully predicted treatment drop-out – though the 95% confidence interval between .163 and 1 makes the magnitude of the effect uncertain. Taken together, all of these findings suggest that attachment avoidance is a potentially relevant variable in the alcohol treatment process, especially given the overrepresentation of insecure attachment styles in the treatment context (Doumas, Blasey, & Mitchell, 2007; Thorberg &

Lyvers, 2006), but further research in a larger sample is necessary to clarify its role and its relationship to other variables. For example, the fact that both higher family satisfaction and higher attachment avoidance predict treatment drop-out even though the latter is associated with significantly *lower* family satisfaction leads to questions about the relationship between these two constructs, whose interaction was not significant in this instance.

The second research question – whether changes occurred in family relationships across the residential rehabilitation process – was also addressed by Study 1. To detect change that occurred in the same direction across families, a series of linear mixed models were run using the longitudinal data from those patients who completed treatment (n=32). Statistically significant change over time was detected in patients' perceptions of their family relationships for two of the family functioning variables tested: rigidity (an extreme of flexibility) and disengagement (an extreme of cohesion). Treatment completers reported a significant reduction in their family's rigidity between intake and discharge from residential rehabilitation, and a significant increase in disengagement from their final month of treatment to one-month follow-up. This suggests that some aspects of family functioning may improve across the rehabilitation process while others deteriorate. Alternatively, in light of the results from Study 2 (discussed below), it is possible that the initial hypotheses of what constitutes improvement and deterioration need to be revised.

These results confirm that family change was occurring across the rehabilitation process as hypothesised, even though it was not anticipated that change would occur in a consistent direction across the sample. This suggests that there may in fact be some processes that are common across families during the transition to sobriety, namely those to do with increasing flexibility and distance in the family system. For the majority of the

variables tested, however, change was not predictable or global, but was still apparent when the longitudinal data was examined graphically on a case-by-case basis. This showed how conflict, communication, cohesion, flexibility and satisfaction varied across time from patient to patient, though the pattern did not often conform to the linear idea of improvement or deterioration that had been hypothesised. Curvilinear trends were common, with families improving and then deteriorating (or the reverse) across the three time points. The most obvious pattern was simply change itself. Perhaps in a larger, more complete sample than the current dataset, which had only 14 of its 32 subjects participating at all three time points, it would be possible to identify discrete groups with predictable patterns of change. This is a possible avenue for future research.

## Study 2: Summary and discussion

Study 2 was designed to further investigate questions of family change during the residential rehabilitation process by speaking directly to alcohol patients and their family members. Interviews with both groups were organised into segments exploring family life before, during and after rehabilitation. Grounded theory methodology, a data-driven method for hypothesis generation, was used to identify common themes and experiences in order to move towards a preliminary explanation of family process in the transition to sobriety.

In their descriptions of life before alcohol rehabilitation, participants in both groups reported more common elements than differences. Family members presented an especially unified view of life before treatment, describing the upheaval and chaos of active drinking, as well as the physical and emotional consequences they endured. Patients, who overwhelmingly maintained a self-focus at this stage, did not routinely recognise their impact on family members, and perhaps would be surprised to hear the

many ways in which their relatives were affected. Conversely, however, patients consistently identified relational issues as triggers to alcohol use, and this idea did not emerge in the interviews with family members. Perhaps the isolation that both groups described as characteristic of family life in this period prevented them from recognising the systemic nature of addiction.

As dependency progressed, family members described vacillating between resignation and action, and remembered their many failed attempts to influence the course of their relative's addiction through ultimatums, rules and boundaries. Patients, however, focused only on how their family members ultimately facilitated treatment entry, the majority through deliberate intervention that took the responsibility out of their hands. This illustrates the key role family members can play in effecting change, even when patients themselves are resistant.

In their descriptions of life during residential treatment, relief was the common overarching theme mentioned by both patients and their family members. Rehabilitation was a time for everyone to rest, though family members also experienced considerable anxiety and anger during this time that patients were largely unaware of. Family members were not offered the professional support patients received, and left to manage these feelings on their own, they began to take steps to decrease their isolation (e.g. confiding in friends and family and engaging with Al-Anon). In the main, patients felt supported by their family members during the treatment process and reported frequent contact with them; family members, though continually involved with patients, also took advantage of their relatives' absence to focus on themselves and their own needs. It was in this phase of the treatment process that more differences began to emerge across the sample. Among both patients and family members there was a subset of participants who used the

separation provoked by treatment to introduce distance into their relationships; these participants deliberately avoided contact during rehabilitation.

Reintegration after discharge was a complex and varied process, with both groups of participants experiencing a range of possible outcomes. At the beginning of this phase, however, family members were united in their continuing anxiety, and patients noticed their relatives stepping back to give them space when they arrived home. Both patients and family members were challenged in different ways by reunion. Not having had the support or guidance that patients had received in treatment, family members did not know what to expect or how to behave after discharge. Patients had been prepared to manage their recoveries, but some were surprised to find themselves back in family systems that had not changed alongside them. For these patients, feelings of impotence emerged akin to those reported by family members during active drinking.

There were also many positive aspects to reunion. Many patients and family members reported a return to calm normality and even improvements in family functioning, such as reduced conflict, increased communication and more meaningful time together. This occurred alongside a general movement towards differentiation, however: patients prioritised their recoveries, asserting their separateness, and family members were free to begin focusing on their own individual needs. Overall, there was a degree of uniformity across the sample, but especially in this last phase, enough variability to suggest there may be subgroups who have different patterns of experience. For example, the subset of participants who began to distance themselves from their relatives during rehabilitation continued this distancing after discharge.

In the current sample then, family life and relationships were indeed changing across the rehabilitation process. There was not one consistent direction for the change,



but there were a surprising number of common experiences, indicating that some aspects of family process during alcohol rehabilitation may be predictable. Distance regulation was a key theme in both the patient and family member samples. For patients, a curvilinear pattern of increasing closeness from before to during treatment followed by a decrease in closeness from discharge to one-month follow-up was described. For family members, there was a gradual opening of the system to outside influence across the process, though participants generally did not report increasing closeness with their alcohol dependent relatives as the patients themselves did. There were also important ways in which both patients and family members did not change. Patients maintained a self-focus throughout the rehabilitation process, in contrast to family members who focused on their relatives until recovery allowed some of them to move towards a self-focus themselves. Family members' anxiety was another constant across the process; even when recovery allowed them more freedom, fear was just below the surface and easily triggered.

#### [Study 1 and Study 2: An integrated view](#)

Comparing the results from Study 1 and Study 2 allowed a broader view of family process during residential rehabilitation to emerge. Taken together, the studies serve to contextualise each other and offer both a patient and a family perspective on the alcohol treatment process. The next section summarises the instances in which findings from the quantitative and qualitative studies combine to increase the explanatory power of both.

One of the more surprising findings from the quantitative study was that patients on average reported normative to healthy family functioning at intake. This was interesting given the amount of evidence in the literature for systemic disruption during active drinking, and suggested that perhaps patients did not accurately perceive the disorder in their family lives. Qualitative interviews with family members confirmed that such

disruption to the family environment was indeed occurring, and interviews with patients supported the idea that they were often oblivious to this. During interviews, patients adopted a persistent self-focus which prevented them from appreciating their impact on family members, even where they recognised their own failures. Further, when prompted, many were insistent that their family members were unaffected by their drinking or reported that they did not realise the impact until they were in treatment.

One of the overarching hypotheses of the research programme was that family change would occur across the rehabilitation process but it was not anticipated that the direction of this change would necessarily be consistent. Some families were expected to improve while others deteriorated, as per the inconsistent pattern of results in the literature. In Study 1, however, two variables changed in the same direction across the sample over time, and in Study 2, grounded theory methodology was used to identify a range of experiences common to patients and family members. Both studies suggest that there may in fact be some processes that appear predictably across families during the transition to residential rehabilitation even as others vary. They also agree on what some of these processes might be.

In Study 1, patients reported that rigidity in their families significantly decreased between intake and discharge from rehabilitation, while disengagement increased significantly from the final month of treatment to one-month follow-up. These findings mirror the general pattern of family process that emerged in interviews. In Study 2, family members discussed how they began to shift, becoming increasingly open to outside influence, during the time their relatives were inpatient, which mirrors the reduction in rigidity reported by patients in the quantitative study during this period. The increased disengagement from discharge to one-month follow-up also reported in Study 1 was

described in Study 2 by both family members and patients. For patients, who in interviews described a curvilinear pattern of increasing and then decreasing closeness across the rehabilitation process, the increase in disengagement seen in the quantitative results corresponds to the reduction in goal-directed support from relatives and their own self-focused prioritisation of recovery in the post-discharge period. Family members, in shifting towards a self-focus themselves and appreciating patients' need to assert their separateness in recovery, also endorsed the idea of disengagement in the final phase of alcohol treatment. Interestingly, a graphical presentation of disengagement in Study 1 that includes the period from intake to discharge (see Figure 3.4) showed two distinct patterns which were consistent with the qualitative findings: the curvilinear pattern described above and also a linear increase in disengagement from baseline. This latter pattern may correspond to the subgroup in Study 2 that used the rehabilitation process to introduce distance into their relationships from the beginning of the process.

In the case of family disengagement, the combination of quantitative and qualitative methods provides sufficient detail to support the revision of an existing hypothesis. It was expected that families would either improve or deteriorate across the rehabilitation process, and as operationalised, disengagement was considered a form of deterioration. Descriptions provided by participants in the qualitative study, however, suggest that disengagement is a more nuanced phenomenon than the quantitative findings alone may have implied. The separateness characterising family life in this stage of the rehabilitation process may not necessarily be indicative of deterioration, but for some families may instead represent a healthy distance taking facilitative of recovery.

While the mixed methods design allowed for the elaboration of processes common across families during alcohol treatment, it also identified subgroups in both studies with

different overall patterns of experience. In Study 2, there was a subset of participants who used the transition to residential rehabilitation to increasingly build separateness into their intimate partner relationships. In Study 1, polydrug users and participants high on attachment avoidance both reported significantly different patterns of distance regulation than their comparison groups. Graphical representations of the 14 subjects who participated in Study 1 at all three time points confirm that there were a variety of patterns of change for each of the family functioning variables tested, but the final sample was too small to reliably identify subgroups. With a larger sample or a better longitudinal response rate, this might have been possible. Determining whether and how the different patterns of family change observed in the study can be organised in a meaningful way would be a useful avenue for future investigation.

### Implications of the research programme

The studies in the current research programme illustrate the significance of family relationships to the core processes of addiction and recovery. As shown in Chapter Two, the relevance of relational factors has been comparatively neglected in the literature, which has largely focused on individual factors that determine alcohol outcomes. Interpersonal models of relapse and recovery, which emphasise the importance of the interaction between inter- and intrapersonal factors (Hunter-Reel et al., 2009; Leach & Kranzler, 2013) are supported by the current studies. In Study 2, for example, consistent with the literature on individual predictors of relapse to alcohol use (Boschloo et al., 2012; Willinger et al., 2002), nine of the ten interviewees described drinking to manage stress or mood. However, the majority of these participants went on to cite a relational trigger for their affective disturbance, and four of these patients said this relational trigger was the primary reason they were drinking. This example illustrates how considering relational or

family factors can help to contextualise predictive intrapersonal factors, perhaps opening the way for more effectively targeted intervention. In this example, working therapeutically to modify stress levels or mood could be enhanced if combined with interventions aimed at improving the relationships driving the affective response.

That two relational variables, family satisfaction and attachment avoidance, were predictive of treatment completion in Study 1 after accounting for known individual predictors of outcome further supports the idea that family process should be a relevant consideration at the point of treatment entry. Study 1's seemingly counterintuitive finding that patients' satisfaction with family life was predictive of treatment drop-out requires us to revisit ideas about recovery capital presented in Chapter One. Rather than acting as a resource, in these families, patients' subjective feelings of satisfaction appear to jeopardise their success. Perhaps within this finding is an opportunity for improving the odds of treatment completion. Findings from Study 2 also suggest that family members are highly anxious about their relatives' engagement with treatment during rehabilitation and supportive of their efforts to achieve sobriety. Previous research also shows that active family involvement facilitates treatment entry and adherence (Meis et al., 2013; O'Farrell & Clements, 2012; Rowe, 2012). If treatment providers were to make a concerted effort to engage families in the rehabilitation process, perhaps the risk that perceived satisfaction with family life will prevent patients from committing to treatment could be mitigated and these relationships used as a resource instead.

Interviews with family members in Study 2 identified many ways in which families themselves needed support during the transition to recovery. Families experienced considerable anxiety throughout the alcohol treatment process and though family therapy was available to participants in the qualitative sample who had attended Rehabilitation

Centre B, there was no integrated professional support or guidance specific to the family experience. (Family therapy was part of the service offering to patients and focused on their needs.) In the quantitative study, only 5 of the 21 participants who returned their questionnaires at time two had had access to any family programming at all during rehabilitation. As described in detail in Chapter One, accessibility of family services is extremely limited in the alcohol treatment context today; the qualitative sample's access to family therapy was exceptional, and yet they still felt lost in the treatment process due to the lack of services tailored to their experience. Providing these would not only fill a pressing need for family members, but would also go some way towards mitigating the risk of patient drop-out for those with high family satisfaction. Some suggestions for family-specific interventions follow.

Both during and after rehabilitation, family members would have benefitted from specific support to help clarify expectations around the transition to recovery, including how to manage their emotional response and their interactions with patients. Evidence from the qualitative study indicates that during treatment itself, while patients were absent from the home, family members were dealing with a complex mixture of emotions and anxiety, and as discharge neared, became increasingly nervous about reintegration. Family-specific programming running in parallel to rehabilitation could help provide relatives with a space for processing and normalising these reactions, as well as preparing them for the eventuality of reunion and the realities of early recovery, including the potential for patients to introduce distance as they prioritise abstinence. Family members could also be taught to recognise their own effectiveness as agents of change: as Study 2 and other studies show (Meis et al., 2013; O'Farrell & Clements, 2012; Rowe, 2012), families *are* effective at facilitating treatment entry and adherence. Twelve step

programmes that emphasise relatives' powerlessness may help family members to establish boundaries and protect their independence, but perhaps in early recovery, helping families recognise that they can drive and maintain change better serves both patients and their family members.

Finally, the results of the current programme of research challenge the traditional systemic model of addiction and recovery, which conceptualises alcohol dependence as coming to occupy a functional role in family life that families seek unconsciously to protect (Steinglass et al., 1987). While there was one example in Study 2 where alcohol had made socialising as a couple easier during active drinking and more difficult in recovery, overall the families interviewed welcomed the removal of alcohol from the family context and were not themselves destabilised by the change. Linear patterns of deterioration based on baseline organisation around addictive behaviour were hypothesised, but not ultimately identified in the quantitative sample. Newer systemic models which emphasise the need for families to introduce healthy distance during recovery (Brown & Lewis, 1999) or which highlight the normative nature of families' response to stress (Orford, Copello, et al., 2010) were more theoretically compatible with the findings of this thesis.

By elucidating family process during a unique moment in the life cycle of families dealing with alcohol dependence, Studies 1 and 2 contribute to the as yet small literatures on interpersonal predictors of treatment outcome and wet-to-dry transitions in the family context. In the former case, Study 1 identifies satisfaction with family life and attachment avoidance as relational variables predictive of outcome alongside social support and marital status (Adamson et al., 2009; Beattie, 2001; Beattie & Longabaugh, 1999; Boschloo et al., 2012; Walter et al., 2006). In the latter case, Studies 1 and 2 provide

evidence of family change across the residential rehabilitation process, just as family change can be observed when day to day alcohol consumption changes (Frankenstein et al., 1985; Haber & Jacob, 1997; Haughland, 2005; Jacob & Leonard, 1988; Leonard & Roberts, 1998; Liepman et al., 1989; Liepman et al., 2008) or when families move between relapse and recovery (Andreas et al., 2006; Andreas & O'Farrell, 2007; Moos & Billings, 1982; Moos & Moos, 1984; Weisner et al., 2010). Both of these additions to the literature strengthen the overall case for a systemic formulation of addiction and recovery – one that may ultimately drive the inclusion of families in the alcohol rehabilitation process.

### Limitations of the current studies

*Study 1.* As discussed in Chapter Three, one of the key limitations of Study 1 was its reliance on patient self-report data. Using patients' perspectives on family life to predict outcomes is a sensible step towards developing more effective interventions for this population at point of treatment, but their data alone presents a limited view on the question of family change. The qualitative study went some way towards making up for this shortcoming, but collecting longitudinal family functioning data directly from relatives in real time would have greatly increased our understanding of family process during residential rehabilitation. This was the original study design, which could not be carried out due to a lack of access to relatives in the treatment context – a result of the lack of integration of families in the rehabilitation process generally. Study 1 raised many questions about the family's experience that could have been answered had this study design been feasible. For example, would families have rated their functioning as normative to healthy at baseline as patients did? The qualitative results suggest not, and there is evidence that alcohol patients' perceptions of family life do not correlate well with those of their family members at pre-treatment (McKay, Maisto, Beattie, Longabaugh, &



Noel, 1993). How then would relatives' baseline family satisfaction have compared with that reported by patients, especially those whose high satisfaction was ultimately associated with poor treatment outcomes? Would family members' reports of functioning have been better predictors of patient outcome than the patients' reports themselves? It is possible that family satisfaction as reported by patients is actually a complex variable which in some cases reflects patients' denial of or disconnection from their impact on family life. Collecting family members' ratings would help to contextualise patients' responses, which alone may give an incomplete picture of the family's transition to residential rehabilitation.

A second limitation of Study 1 was the relatively low rate at which questionnaires were returned at time two (51%) and time three (47%). This weakened the conclusions that could be drawn about family change longitudinally. Additionally, questionnaires were only administered to patients who were still engaged in treatment, so any family change occurring in unsuccessful cases was not captured. It would be interesting to observe patterns of change in treatment drop-outs as well. This would require an effective way of maintaining contact with patients who have relapsed, or a matched family sample whose ratings could add detail where patient data was missing.

The measures used to operationalise family functioning had several limitations which introduced questions of interpretation into the study. Patients often struggled to complete the questionnaires, answering as though they weren't part of the family they were describing. They made comments like "I'd say they tend to be highly organised apart from me," and endorsed items like 'family members are close to one another' as strongly agree because they are "close to each other, but not to me." This pattern of response is in keeping with findings from Study 2 which highlighted isolation from their families as a

theme for alcohol patients. Patients also reported having different relationships with different members of their families and sometimes found it difficult to give the sort of global evaluation required by the measures. One participant, for example, said that his positive responses had been about his sister and the negative ones about the rest of the family. Lastly, patients often could not relate to the concept of “family” as defined by the measures, which largely assumed that respondents belonged to a cohabiting nuclear household – something not in keeping with the reality of many systems dealing with addiction, including the majority of the sample population of Study 1. It is perhaps because of these shortcomings that family satisfaction was the variable most predictive of outcome in the current study. While other variables are fraught by the unique relationship between alcohol patients and their families, family satisfaction measures simply ask respondents to report the extent to which they are happy with these relationships – a proxy measure for their potential impact on patients.

Just as the standard conceptualisations of family could not be assumed when working with this population, other variables used in the study may need to be understood differently in the context of addiction as well, especially disengagement. The FACES-IV measure, which is organised around the core dimensions of cohesion and flexibility, considers disengagement to be an unhealthy extreme of cohesion. In this respect, a conventional interpretation of the variable stands to pathologise what may actually be a healthy process at this stage of life for families making the transition to sobriety. Without the qualitative findings to provide detail on this point, a very different picture of post-discharge family life would have emerged. Given all of the evidence above, researchers working with substance misuse must question whether traditional measures are appropriate for this population.

*Study 2.* As discussed in Chapter Four, Study 2 ultimately presents an initial series of hypotheses to guide the development of a fully-fledged grounded theory of family process during alcohol rehabilitation. This means that the conclusions drawn are preliminary; further interviewing is required to refine their content and determine whether they are applicable to wider populations. This is especially true as the current sample cannot be said to be representative of the treatment population in general. It differs in two key respects. First, the vast majority of both the patient sample and the relatives of those interviewed in the family member sample were still maintaining abstinence at the time of interview (18 of 20 cases). Additionally, treatment had been delivered largely in private facilities (17 of 20 cases). This means that participants in both groups may differ in important ways from others going through the rehabilitation process.

That the sample was largely successful in maintaining abstinence after discharge calls into question whether the patterns of family process identified in Study 2 are applicable to those who ultimately experienced treatment failure. Additional interviews with those who relapsed and their family members would serve to clarify which processes are common to the experience of residential treatment in general and which may be specific to successful or unsuccessful cases. These distinctions could help drive further research into patterns and processes that might facilitate the maintenance of abstinence. In terms of the second source of bias in the sample, those undertaking treatment in a private facility are likely to have advantages not available to the wider treatment population, such as access to greater financial resources and exposure to family programming. This latter point especially means that participants in the current study, despite family members' feelings of being neglected in the treatment setting, may still have had more systemic insight or guidance than patients in other programmes. Intentionally or not, this may be

reflected in the narratives they presented at interview and contribute to the conclusions drawn from them.

Methodologically, Study 2 can be said to have the following limitations. First, due to the time-limited nature of the study, the focus of initial interviews may have been narrowed more quickly than usual; it is possible that this prevented other possible themes from emerging or limited repetition of developing themes in more heterogeneous samples (e.g. the family member sample). Second, while there was only one instance in which participants in a subsample were from the same family (2 participants in the family member sample were related), there were 4 cases in which participants were paired across groups. Thus, while neither the qualitative analysis for patients or family members was limited by data dependency, when drawing broader conclusions across groups it should be remembered that the samples were not completely independent of one another. Finally, as with any qualitative study in a constructionist tradition, it must be noted that the interpretation of data is coloured by the ideas and experiences of the researchers analysing it. While rigorous quality control mechanisms were in place in accordance with grounded theory methodology (e.g. defining preconceptions and biases in advance, using multiple coders, memo writing), it is possible that traces of the author remain.

### Ideas for future research

Suggestions for future research appear throughout this chapter. A few key avenues for further investigation will be summarised here. Following on from Study 1, a parallel longitudinal study of family members during the rehabilitation process would contextualise patients' responses (for example, their reporting normative to healthy family functioning at intake) and give a more complete view of family change during treatment. Such a study would also help us understand whether there were baseline family predictors of treatment

completion, which might suggest new targets for systemic intervention. Additionally, the following findings from Study 1 merit specific exploration in a larger sample with a better longitudinal response rate: (1) the observation that treatment drop-outs reported healthier family functioning on nearly every measure than treatment completers, (2) the role of attachment as a predictor of outcome and its relationship to other family functioning variables, and (3) the potential for predictable differences in the patterns of response of various subgroups (e.g. among polydrug users or those high on attachment avoidance). As Study 1 is the first to investigate family process prospectively during residential alcohol treatment, there are many potential directions for continuing research in this area.

The obvious strategy for advancing the work begun in Study 2 is simply to continue interviewing according to the methodology presented, moving towards the grounded theory that is its ultimate goal. Extending interviews to the wider treatment population, including unsuccessful cases, would help to test the limits of the hypotheses developed in the current study. Additionally, the presence of a subgroup in both the patient and family member samples that reported a different pattern of change from the majority – i.e. who increasingly introduced distance across the rehabilitation process – suggests another direction for future research. As in Study 1, where there was also evidence that certain subgroups may have predictable patterns of relational response to treatment, it would be useful to further explore the existence of such patterns and whether they are associated with specific characteristics in the population. If so, this might suggest improvements to treatment, which could be tailored more appropriately to patients and their relationships.

## Conclusion

The current programme of research has shown that family process is indeed a relevant consideration at the point of residential rehabilitation. Patients' satisfaction with their family relationships is predictive of treatment outcome, and families themselves experience considerable change across the rehabilitation process. Given this, the relative neglect of families in the treatment setting merits reconsideration. It is in everyone's best interests – patients, family members, and treatment providers – to move towards a more systemic view of alcohol dependence and recovery. Continuing research on this topic would contribute to such a shift in thinking.

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## Appendices

### Appendix 1: Participant information sheet, Study 1

#### **Participant Information Sheet for service users**

**Study Title:** The family's response to alcohol rehabilitation

Before you agree to take part in this study, we would like you to understand the purpose of the research and what participation will involve.

*What is the purpose of the study?*

This study seeks to understand the impact on families when one member enters an alcohol treatment programme.

*Why have I been invited?*

We are inviting service users who are about to begin a residential alcohol rehabilitation programme and meet ANY of the following conditions:

- (1) have children (including grown children)
- (2) have a current partner
- (3) live with or are supported by a family member.

*Do I have to take part?*

No, it is up to you to decide to join the study. We will discuss the study with you and go through this information sheet. Before you actually participate, we will ask you to sign a consent form. Whether or not you participate will not affect the standard of care you receive, and you are free to withdraw at any time, without giving a reason.

*What will happen if I take part?*

Participation takes place at three time points: (1) when you first enter inpatient alcohol detoxification, (2) in your last weeks of residential treatment and (3) one month after discharge.

(1) When you first enter inpatient alcohol detoxification, we will ask you to fill out a set of questionnaires exploring your family relationships and individual functioning during this time. We estimate these questionnaires will take between 45 minutes and 1 hour to complete. We will also ask you about your alcohol and other drug use (if applicable) during the past 30 days. This will involve completing two further questionnaires and a 15-20 minute interview with a researcher. All of this will take place in the detoxification centre.

(2) During your last month of residential rehabilitation, we'll ask you to complete some of the questionnaires from step 1 again – specifically those to do with your family relationships and individual functioning. This will take place in your rehabilitation centre or by post.

(3) A month after you've been discharged, we'll repeat the process described in step 1 in full. This time, you will have the option to participate in person at the treatment facility or from home (in the latter case, the interview will be by phone and the questionnaires sent by post or completed online, though the researcher can arrange to visit you in exceptional circumstances).

*What are the possible disadvantages of taking part?*

It is possible that thinking about the effects of alcoholism on your family will be distressing for you. The researcher is available should you wish to debrief after participating (either in person or by phone). If you require further psychological support once your research involvement has ended, we can help you find appropriate services.

*What are the possible benefits of taking part?*

There are no direct benefits to taking part in the research, but participants completing all three time points will be entered into a "lucky draw" to win one of three retail vouchers (£70, £20, £10). Additionally, we hope the information we get from this study will help improve the experience of other families facing inpatient alcohol treatment. You may find you experience increased insight into your own family processes through participating.

*Will my taking part in the study be kept confidential?*

Your data are strictly confidential. We will not discuss, present or publish your data in any way that identifies you. All questionnaires will be stored in a locked cabinet in a locked office, and electronic records kept on a password-protected university computer, accessible only to the researcher. Data will be analysed anonymously, stored for five years and then destroyed.

It is important to note here the limits of confidentiality: if during the course of the research we become aware that you or someone else, especially a child, is at risk of serious harm, we will be obligated to report this to the authorities. Where such disclosures need to be made, they will be made with your full knowledge.

*What if there is a problem?*

If you have any concerns about any aspects of the study, you should contact the researcher, who will do her best to answer your questions. You can reach her by email ([andrea.rosen@kcl.ac.uk](mailto:andrea.rosen@kcl.ac.uk)) or phone (020 7848 0972). If you remain unhappy and wish to complain formally, you can do this through the treatment institution where you were recruited.

*Am I free to withdraw at any point?*

Yes. Please use the contact details below to withdraw at any point. The information collected will be destroyed if you wish.

*What happens when the research study stops?*

The final results of the study will be available to participants upon request.

*Who is carrying out the research?*

This study is part of Ms Andrea Rosen's PhD research at the Institute of Psychiatry, King's College London, and is funded by the Economic and Social Research Council. Ms Rosen (BA psychology, MSc marital & family therapy) is supervised by Professor Ivan Eisler (Head of Section of Family Therapy, Institute of Psychiatry) and Dr Jane Marshall (Consultant Psychiatrist in Alcohol Studies, South London and Maudsley NHS Foundation Trust).

*Who has reviewed the study?*

The study has been reviewed by the South East London Research Ethics Committee, REC reference number 13/LO/0470.

For further information, please contact:

Andrea Rosen, PhD student

Dept of Psychology, Institute of Psychiatry, King's College London

Ph: 0207 848 0972

[andrea.rosen@kcl.ac.uk](mailto:andrea.rosen@kcl.ac.uk)

**Participant Consent Form for service users**

**Study Title: The family's response to alcohol rehabilitation**

*Please initial*

I confirm that I have read and understood the information sheet for participants dated 3 October 2013 (Version 6) and have had the opportunity to ask questions.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and my medical care or legal rights will not be affected.

☐

I understand that my data will be kept confidential and anonymous, subject to the limitations described in the information sheet (dated 3 October 2013, Version 6).

☐

I give permission for appropriate sections of my medical records to be made available to the research team where it is relevant to my taking part in this research.

☐

I give permission for the research team to use the contact details I provide in order to locate me during the later stages of the study, both in residential rehabilitation and after discharge, or to contact the locators I provide in the event that I cannot be contacted.

☐

I agree to take part in the above study.

☐

Name of Participant.....

Signed ..... Date.....

Researcher.....

Signed ..... Date.....

**For further information please contact:** Andrea Rosen, PhD student,  
Department of Psychology, Institute of Psychiatry, King's College London  
Tel: 020 7848 0972  
Email: [andrea.rosen@kcl.ac.uk](mailto:andrea.rosen@kcl.ac.uk)

**Participant Information Sheet for service users**

**Study Title:** The family's response to alcohol rehabilitation

Before you agree to take part in this study, we would like you to understand the purpose of the research and what participation will involve.

*What is the purpose of the study?*

This study seeks to understand the impact on families when one member enters an alcohol treatment programme.

*Why have I been invited?*

We are inviting service users who are currently completing or have recently completed an inpatient alcohol treatment programme to participate, along with their partners or another close family member (if possible).

*Do I have to take part?*

No, it is up to you to decide to join the study. We will discuss the study with you and go through this information sheet. Before you actually participate, we will ask you to sign a consent form. Whether or not you participate will not affect the standard of care you receive, and you are free to withdraw at any time, without giving a reason.

*What will happen if I take part?*

You will complete a single interview session with a researcher lasting approximately 45 minutes. You will be asked to discuss what changed in your family when you left home for inpatient alcohol treatment and to describe what it was like when you returned. You will be interviewed individually, and your responses will not be shared. Please note that interviews will be recorded (audio only). You will have the opportunity to review a transcript of your interview upon request.

*What are the possible disadvantages of taking part?*

It is possible that thinking about or discussing the effects of alcoholism on your family will be distressing for you. The researcher is available should you wish to debrief after the interview. If you require further psychological support once your research involvement has ended, we can help you find appropriate services.

*What are the possible benefits of taking part?*

There are no direct benefits to taking part in the research, but we hope the information we get from this study will help improve the experience of other families facing inpatient alcohol treatment. You may find you experience increased insight into your own family processes through participating.

*Will my taking part in the study be kept confidential?*

Your data are strictly confidential. While we may use direct quotations from the interviews in our work, we will not discuss, present or publish your data in any way that identifies you. Interviews will be downloaded to a password-protected university computer, accessible only to the researcher, and stored under an ID number to ensure anonymity. Audio files will be destroyed after 5 years.

It is important to note here the limits of confidentiality: if during the course of the research we become aware that you or someone else, especially a child, is at risk of serious harm, we will be obligated to report this to the authorities. Where such disclosures need to be made, they will be made with your full knowledge.

*What if there is a problem?*

If you have any concerns about any aspects of the study, you should contact the researcher, who will do her best to answer your questions. You can reach her by email ([andrea.rosen@kcl.ac.uk](mailto:andrea.rosen@kcl.ac.uk)) or phone (020 7848 0972). If you remain unhappy and wish to complain formally, you can do this through the treatment institution where you were recruited.

*Am I free to withdraw at any point?*

Yes. Please use the contact details below to withdraw at any point. The information collected will be destroyed if you wish.

*What happens when the research study stops?*

The final results of the study will be available to participants upon request.

*Who is carrying out the research?*

This study is part of Ms Andrea Rosen's PhD research at the Institute of Psychiatry, King's College London, and is funded by the Economic and Social Research Council. Ms Rosen (BA psychology, MSc marital & family therapy) is supervised by Professor Ivan Eisler (Head of Section of Family Therapy, Institute of Psychiatry) and Dr Jane Marshall (Consultant Psychiatrist in Alcohol Studies, South London and Maudsley NHS Foundation Trust).

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The study has been reviewed by the South East London Research Ethics Committee, REC reference number 13/LO/0470.

*For further information, please contact:*

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Ph: 0207 848 0972  
[andrea.rosen@kcl.ac.uk](mailto:andrea.rosen@kcl.ac.uk)

**Participant Information Sheet for partners or relatives**

**Study Title:** The family's response to alcohol rehabilitation

Before you agree to take part in this study, we would like you to understand the purpose of the research and what participation will involve.

*What is the purpose of the study?*

This study seeks to understand the impact on families when one member enters an alcohol treatment programme.

*Why have I been invited?*

We are inviting service users who are currently completing or have recently completed an inpatient alcohol treatment programme to participate, along with their partners or another close family member.

*Do I have to take part?*

No, it is up to you to decide to join the study. We will discuss the study with you and go through this information sheet, either in person or by phone, before you decide to participate. On the day of the interview itself, we'll ask you to sign a consent form. Whether or not you participate will not affect the standard of care your partner or relative receives, and you are free to withdraw at any time, without giving a reason.

*What will happen if I take part?*

You will complete a single interview session with a researcher lasting approximately 45 minutes. You will be asked to discuss what changed in your family when your partner or relative left home for inpatient alcohol treatment and to describe what it was like when he or she returned. You will be interviewed individually, and your responses will not be shared. Please note that interviews will be recorded (audio only). You will have the opportunity to review a transcript of your interview upon request.

*What are the possible disadvantages of taking part?*

It is possible that thinking about or discussing the effects of alcoholism on your family will be distressing for you. The researcher is available should you wish to debrief after the interview. If you require further psychological support once your research involvement has ended, we can help you find appropriate services.

*What are the possible benefits of taking part?*

There are no direct benefits to taking part in the research, but we hope the information we get from this study will help improve the experience of other families facing inpatient alcohol treatment. You may find you experience increased insight into your own family processes through participating.

*Will my taking part in the study be kept confidential?*

Your data are strictly confidential. While we may use direct quotations from the interviews in our work, we will not discuss, present or publish your data in any way that identifies you. Interviews will be downloaded to a password-protected university computer, accessible only to the researcher, and stored under an ID number to ensure anonymity. Audio files will be destroyed after 5 years.

It is important to note here the limits of confidentiality: if during the course of the research we become aware that you or someone else, especially a child, is at risk of serious harm, we will be obligated to report this to the authorities. Where such disclosures need to be made, they will be made with your full knowledge.

*What if there is a problem?*

If you have any concerns about any aspects of the study, you should contact the researcher, who will do her best to answer your questions. You can reach her by email ([andrea.rosen@kcl.ac.uk](mailto:andrea.rosen@kcl.ac.uk)) or phone (020 7848 0972). If you remain unhappy and wish to complain formally, you can do this through the treatment institution where you were recruited.

*Am I free to withdraw at any point?*

Yes. Please use the contact details below to withdraw at any point. The information collected will be destroyed if you wish.

*What happens when the research study stops?*

The final results of the study will be available to participants upon request.

*Who is carrying out the research?*

This study is part of Ms Andrea Rosen's PhD research at the Institute of Psychiatry, King's College London, and is funded by the Economic and Social Research Council. Ms Rosen (BA psychology, MSc marital & family therapy) is supervised by Professor Ivan Eisler (Head of Section of Family Therapy, Institute of Psychiatry) and Dr Jane Marshall (Consultant Psychiatrist in Alcohol Studies, South London and Maudsley NHS Foundation Trust).

*Who has reviewed the study?*

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Ph: 0207 848 0972  
[andrea.rosen@kcl.ac.uk](mailto:andrea.rosen@kcl.ac.uk)



## Participant Consent Form for patients

### Study Title: The family's response to alcohol rehabilitation

*Please  
initial*

I confirm that I have read and understood the information sheet for participants dated 23 Oct 2013 (Version 6) and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and my medical care or legal rights will not be affected.

I understand that my data will be kept confidential and anonymous, subject to the limitations described in the information sheet (dated 23 Oct 2013, version 6).

I agree to take part in the above study.

Name of Participant.....

Signed ..... Date.....

Researcher.....

Signed ..... Date.....

**For further information please contact:** Andrea Rosen, PhD student,  
Department of Psychology, Institute of Psychiatry, King's College London  
Tel: 020 7848 0972  
Email: [andrea.rosen@kcl.ac.uk](mailto:andrea.rosen@kcl.ac.uk)

**Participant Consent Form for partners and relatives**

**Study Title: The family's response to alcohol rehabilitation**

*Please  
initial*

I confirm that I have read and understood the information sheet for participants dated 23 Oct 2013 (Version 6) and have had the opportunity to ask questions.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and my/my partner or relative's medical care or legal rights will not be affected.

☐

I understand that my data will be kept confidential and anonymous, subject to the limitations described in the information sheet (dated 23 Oct 2013, version 6).

☐

I agree to take part in the above study.

☐

Name of Participant.....

Signed ..... Date.....

Researcher.....

Signed ..... Date.....

**For further information please contact:** Andrea Rosen, PhD student,  
Department of Psychology, Institute of Psychiatry, King's College London  
Tel: 020 7848 0972  
Email: andrea.rosen@kcl.ac.uk

## Appendix 7: Sample items from study measures

### Severity of Alcohol Dependence Questionnaire (SADQ; Stockwell et al., 1994)

1. The day after drinking alcohol, I woke up feeling sweaty.

ALMOST NEVER                      SOMETIMES                      OFTEN                      NEARLY ALWAYS

2. The day after drinking alcohol, my hands shook first thing in the morning.

ALMOST NEVER                      SOMETIMES                      OFTEN                      NEARLY ALWAYS

3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink.

ALMOST NEVER                      SOMETIMES                      OFTEN                      NEARLY ALWAYS

4. The day after drinking alcohol, I woke up absolutely drenched in sweat.

ALMOST NEVER                      SOMETIMES                      OFTEN                      NEARLY ALWAYS

### Alcohol Problems Questionnaire (APQ; Drummond, 1990)

|  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Have you tended to drink on your own more than you used to?                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you worried about meeting your friends again the day after a drinking session? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you spent more time with drinking friends than other kinds of friends?         | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have your friends criticised you for drinking too much?                             | <input type="checkbox"/> | <input type="checkbox"/> |

### Important People Interview (IPI; Longabaugh et al., 2010)

1. What's your partner's drinking/drug use status?

- A. Heavy drinker or user
- B. Moderate drinker or user
- C. Light drinker or user
- D. Abstainer
- E. Recovering alcoholic or drug user
- F. Don't know

2. How often does your partner drink alcohol or use drugs?
  - A. Daily
  - B. 3-6 times/week
  - C. 1-2 times/week
  - D. About every other week
  - E. About once a month
  - F. Less often than monthly
  - G. Once in the past four months
  - H. Not in the past four months
  - I. Don't know
  
3. How has your partner reacted to your drinking or drug use?
  - A. Encouraged
  - B. Accepted
  - C. Neutral
  - D. Did not accept
  - E. Left, or made you leave when you're drinking or using drugs
  - F. Don't know
  
4. How has your partner felt about your coming for treatment?
  - A. Strongly supports it
  - B. Supports it
  - C. Neutral
  - D. Mixed
  - E. Opposes it
  - F. Strongly opposes it
  - G. Don't know how they feel about it

Hopkins Symptom Checklist 25 (HSCL-25; Hesbacher, Rickels, Morris, Newman, & Rosenfeld, 1980)

|                                   | Not at all            | A little              | Quite a bit           | Extremely             |
|-----------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Suddenly scared for no reason     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Feeling restless, can't sit still | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Crying easily                     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Feeling trapped or caught         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Family Adaptability and Cohesion Scale IV (FACES-IV package; Olson, 2011)

|  | Strongly Disagree     | Generally Disagree    | Undecided             | Generally Agree       | Strongly Agree        |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Family members are involved in each other's lives.              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Our family tries new ways of dealing with problems.             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. We get along better with people outside our family than inside. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. We spend too much time together.                                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Family Communication Scale (FACES-IV package; Olson, 2011)

|  | Strongly Disagree     | Generally Disagree    | Undecided             | Generally Agree       | Strongly Agree        |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| 1. Family members are satisfied with how they communicate with each other. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2. Family members are very good listeners.                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3. Family members express affection to each other.                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4. Family members are able to ask each other for what they want.           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

Family Satisfaction Scale (FACES-IV package; Olson, 2011)

|   | Very<br>dissatisfied  | Somewhat<br>dissatisfied | Generally<br>satisfied | Very<br>satisfied     | Extremely<br>satisfied |
|---|-----------------------|--------------------------|------------------------|-----------------------|------------------------|
| 1. The degree of closeness between family members.      | <input type="radio"/> | <input type="radio"/>    | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/>  |
| 2. Your family's ability to cope with stress.           | <input type="radio"/> | <input type="radio"/>    | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/>  |
| 3. Your family's ability to be flexible.                | <input type="radio"/> | <input type="radio"/>    | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/>  |
| 4. Your family's ability to share positive experiences. | <input type="radio"/> | <input type="radio"/>    | <input type="radio"/>  | <input type="radio"/> | <input type="radio"/>  |

Family Environment Scale (FES; Moos & Moos, 2009)

|   | True                  | False                 |
|---|-----------------------|-----------------------|
| 1. We fight a lot in our family                             | <input type="radio"/> | <input type="radio"/> |
| 2. Family members rarely become openly angry.               | <input type="radio"/> | <input type="radio"/> |
| 3. Family members sometimes get so angry they throw things. | <input type="radio"/> | <input type="radio"/> |
| 4. Family members hardly ever lose their tempers.           | <input type="radio"/> | <input type="radio"/> |

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Experiences in Close Relationships Revised scale (ECR-R; Fraley, Waller, & Brennan, 2000)

|  | Strongly Disagree     | Disagree              | Somewhat Disagree     | Neither Agree nor Disagree | Somewhat Agree        | Agree                 | Strongly Agree        |
|--|-----------------------|-----------------------|-----------------------|----------------------------|-----------------------|-----------------------|-----------------------|
| I am nervous when my partner gets too close to me.   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| I talk things over with my partner.                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| It helps to turn to my partner in times of need.     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| It's easy for me to be affectionate with my partner. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/>      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |